STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155218	A. BUILDING 00 B. WING	10/23/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
KINDRED TRANSITIONAL CARE AND REHABILITATION-DYER	2300 GREAT LAKES DR DYER, IN 46311

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F0000	This visit was for a Recertification and State Licensure Survey. This visit included the Investigation of Complaint IN00117033. Complaint IN00117033-Substantiated. Federal/state deficiencies related to the allegations are cited at F166. Survey dates: October 15, 16, 17, 18, 19, 22, & 23, 2012 Facility number: 000123 Provider number: 155218 AIM number: 100266720 Survey team: Lara Richards, R.N., T.C. Heather Tuttle, R.N. Kathleen "Kitty" Vargas, R.N. Census bed type: SNF/NF: 136 Total: 136 Census payor type: Medicare: 36 Medicaid: 77 Other: 23 Total: 136 These deficiencies reflect state	F0000	This Plan of Correction is submitted under the State and Federal Regulations and Statues applicable to long-term care providers. This Plan of Correction does not constitute an admission on part of the facility. We request this Plan of Correction serve as our credible allegation of compliance. Should you have any questions, please feel free to cntact me at (219) 322-3555.Sincerely,Margaret Moore Executive Director	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

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	findings cited in accordance with 410 IAC 16.2. Quality review completed on October 29, 2012 by Bev Faulkner, RN			

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F0164 SS=A	483.10(e), 483.75(l)(4) PERSONAL PRIVACY/CONFIDENTIALITY OF RECORDS The resident has the right to personal privacy and confidentiality of his or her personal and clinical records. Personal privacy includes accommodations, medical treatment, written and telephone communications, personal care, visits, and meetings of family and resident groups, but this does not require the facility to provide a private room for each resident. Except as provided in paragraph (e)(3) of this section, the resident may approve or refuse the release of personal and clinical records to any individual outside the facility. The resident's right to refuse release of personal and clinical records does not apply when the resident is transferred to another health care institution; or record release is required by law. The facility must keep confidential all information contained in the resident's records, regardless of the form or storage methods, except when release is required by transfer to another healthcare institution; law; third party payment contract; or the resident. Based on observation and interview, the facility failed to ensure that privacy was provided while toileting for 1 of 1 male shower rooms on the West Unit. This deficient practice had the potential to affect 12 males residing on the unit. (West Unit)	F0164	1.The 12 male residents using the West unit shower room had the potential to be affected. 2.A privacy curtain has been installed in the West unit shower room. 3.Education has been completed with the housekeeping supervisor and staff on Privacy & Confidentiality.	11/22/2012

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	Findings include: The Environmental Tour was conducted on 10/19/12 at 1:35 p.m., with the Maintenance Supervisor, the Maintenance Assistant, the Housekeeping Supervisor and the Environmental Consultant. The men's shower room on the West Unit was observed. There was no privacy curtain around the toilet. There was a rail with hooks attached to the ceiling around the toilet, but no privacy curtain was attached to the hooks. Interview with the Housekeeping Supervisor at the time, indicated the privacy curtain around the toilet was missing. She indicated she did not know why the privacy curtain was not on the curtain rail. She indicated there was to be a privacy curtain in use. 3.1-3(p)(4)		4.The ED/Designee will audit all shower rooms for maintenance of shower curtains once a week for one month, then twice a month for one month, then once a month for four months. The results of the audit will be presented in monthly PI meeting and the PI committee will determine if 100% compliance has been achieved or needed monitoring is required.	

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F0166 SS=D	483.10(f)(2) RIGHT TO PROMPT EFFORTS TO RESOLVE GRIEVANCES A resident has the right to prompt efforts by the facility to resolve grievances the resident may have, including those with respect to the behavior of other residents. Based on observation, record review and interview, the facility failed to ensure grievances related to a missing wheelchair and missing clothing were promptly resolved for 2 of 3 grievances reviewed. (Residents #B and #C) Findings include: 1. On 10/17/12 at 8:25 a.m., Resident #B was observed in the Main Dining Room seated in her wheelchair. Her right leg was elevated on the foot pedal. Her left leg was free to propel herself and her right arm was resting on the half lap tray. The record for Resident #B was reviewed on 10/17/12 at 2:11 p.m. The resident's diagnoses included, but was not limited to, hemiplegia (weakness to one side of the body). The Annual Minimum Data Set (MDS) assessment, completed 8/7/12, indicated the resident needed supervision and set up help for	F0166	1.Resident B and her family have been notified of the discovery of her personal wheelchair and her family has decided they no longer want the wheelchair and have requested the facility to dispose of the wheelchair. Resident C has been reimbursed for missing shirts. 2. Any resident with a complaint or grievance has the potential to be affected. All complaints and grievances have been audited for resolution and documentation for the past 90 days and on going follow up conducted if necessary.3. Education of all department heads, licensed nurses and the ED has been completed on Complaints/Grievances with emphasis on notification of progress on resolution of the complaint/grievance within 3 days of the initial complaint/grievance, documentation in the resident medical record, and on-going follow up to validate resolution and that the resident/family member are satisfied with the resolution.4. The ED/Designee will review the complaints/grievances log to ensure resolution at least once a week and document on the form	11/22/2012

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	locomotion on and off the unit. Interview with Restorative CNA #1 on 10/23/12 at 12:50 p.m., indicated about a month ago, there were issues with the resident's wheelchair and the former Restorative CNA took the resident's wheelchair and replaced it with a facility wheelchair. The CNA was not aware if that was the resident's personal wheelchair. Interview with CNA #3 on 10/23/12 at 2:10 p.m., indicated the resident's wheelchair was replaced due to the wheel not functioning, it was making it hard for the resident to propel herself in the hallway so the former Restorative CNA took the resident's wheelchair and replaced it with a new one. The CNA's were afraid the resident was going to throw herself out of her wheelchair due to the struggle she was having propelling. Interview with Social Service Staff Member #1 on 10/19/12 at 1:25 p.m., indicated that she was not aware of any grievances filed on the resident's behalf for the past 6 months. Interview with Social Service Staff Member #2 on 10/23/12 at 3:04 p.m., indicated that she interviewed Social Service Staff Member #1 who		weekly follow up as an ongoing practice of this facility. The data from the complaints/grievance logs will be tracked monthly to determine compliance with 3 day follow up and continued on-going follow up weekly until resolution is met with resident/family member and reported to the Performance Improvement Committee in Monthly PI meetings.	

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	indicated that she was aware the family voiced a concern about the resident's personal wheelchair being missing, but she did not file a grievance. Continued interview at the time, indicated the resident's responsible party was not notified prior to getting rid of the resident's personal wheelchair. Continued interview with Social Service Staff Member #2 and LPN #6 at 3:30 p.m., indicated the resident's wheelchair was broken and she was issued a new wheelchair. They indicated the resident's wheelchair was thrown away due to the facility issuing her a new one. They indicated the resident's responsible party was not notified prior to the wheelchair being thrown away due to they were not aware the resident's family bought the wheelchair. LPN #6 indicated the resident's personal wheelchair had been missing since approximately 8/7/12. Interview with LPN #6 at 4:00 p.m., indicated the resident's old wheelchair had been found in the storage garage and the family would be notified. 2. Interview with Resident #C's wife on 10/15/12 at 2:30 p.m., indicated the resident was admitted to the facility on 9/4/12. Further interview at			

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	the time, indicated during his first week at the facility, the resident had two shirts missing. The resident's wife indicated that she reported this to staff and she was told to go and buy two new shirts and that she would be reimbursed; however, she had not received a check. Review of the Complaint and Grievance log on 10/17/12 at 1:59 p.m., indicated on 9/18/12 the resident's wife filed a grievance related to 2 missing shirts. Documentation indicated the resident's wife was reimbursed for $25.73 and the grievance was resolved on 9/21/12. Interview with the resident's wife on 10/19/12 at 2:40 p.m., indicated that she had not received her reimbursement for the two shirts. She indicated that she hates to keep asking but she is afraid she will not receive her reimbursement before her husband is discharged next week. Interview with Social Service Staff Member #2 on 10/19/12 at 2:45 p.m., indicated the resident's wife was instructed to buy 2 new shirts and the facility would reimburse her. She indicated the previous Administrator had signed off on the grievance prior			

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	to the resident's wife receiving a check. She was not aware if the previous administrator processed the request for reimbursement to corporate in a timely manner. The Social Worker indicated the resident's wife had still not received her check and they were waiting for the check to arrive from corporate. She indicated if she could have reimbursed from petty cash she would have, but company policy indicates that any type of reimbursement must come from corporate. Review of the facility Complaints/Grievance policy on 10/19/12 at 3:00 p.m., which was provided by the Regional Interim Director of Nursing #2 and identified as current, indicated the following: -"Acknowledge and document the complaint/grievance" -"forward the form to the Executive Director" -"Assign the appropriate Department Head to investigate" -"investigate to validate the complaint/grievance" -"notify resident and/or family/responsible party of progress within three (3) days of initial complaint/grievance" -"determine a resolution"			

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	This Federal tag relates to Complaint IN00117033. 3.1-7(a)(2)			

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F0225 SS=D	483.13(c)(1)(ii)-(iii), (c)(2) - (4) INVESTIGATE/REPORT ALLEGATIONS/INDIVIDUALS The facility must not employ individuals who have been found guilty of abusing, neglecting, or mistreating residents by a court of law; or have had a finding entered into the State nurse aide registry concerning abuse, neglect, mistreatment of residents or misappropriation of their property; and report any knowledge it has of actions by a court of law against an employee, which would indicate unfitness for service as a nurse aide or other facility staff to the State nurse aide registry or licensing authorities. The facility must ensure that all alleged violations involving mistreatment, neglect, or abuse, including injuries of unknown source and misappropriation of resident property are reported immediately to the administrator of the facility and to other officials in accordance with State law through established procedures (including to the State survey and certification agency). The facility must have evidence that all alleged violations are thoroughly investigated, and must prevent further potential abuse while the investigation is in progress. The results of all investigations must be reported to the administrator or his designated representative and to other officials in accordance with State law (including to the State survey and certification agency) within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. Based on record review and	F0225	1.Residebt #61 reported to her	11/22/2012

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	interview, the facility failed to ensure of allegation of verbal abuse was immediately reported to the Administrator for 1 of 3 allegations of abuse reviewed. (Resident #61) Findings include: Interview with Resident #61 on 10/16/12 at 1:54 p.m., indicated that CNA #4 had yelled at her the previous evening when she fell in the shower room. The resident indicated the CNA did not help her enough to transfer from the shower chair to the wheelchair and her leg gave out and she fell. The resident indicated the CNA yelled at her for not helping with the transfer. The resident and her daughter indicated they reported this to the East Unit Manager on 10/16/12. Interview with the East Unit Manager on 10/17/12 at 4:10 p.m., indicated that he met with the resident's daughter on 10/16/12 related to care concerns from the previous evening. He indicated the resident and the resident's daughter did not want CNA #4 caring for the resident anymore. He also indicated the resident was lowered to the floor in the shower room the night before and there was some indication the CNA had raised		daughter and ISDH that on 10/14/2012 after she had been assisted to the floor while transferring from the shower chair with the C.N.A. , the C.N.A. yelled at her. Resident #61's Daughter reported the concern to the Unit Manager on 10/16/2012. The unit manager failed to identify the concern as an allegation of abuse and report to the ED. ISDH surveyors notified the facility DNS on 10/17/2012 about the alleged abuse. The Facility Administration interviewed the resident and her daughter together on 10/17/2012 at 1730. Residnet #61 stated that the C.N.A. had yelled when the nurse and C.N.A. were transferring her to the Wheelchair from the floor and she lifted her right leg. Resident #61 stated she did not believe there was any intent of harm but she could no longer stand on her right leg during the transfer. Pain assessment completed with no findings. MD and daughter were notified of fall and care plan updated for 2 C.N.A.s with transfers in the shower. The Nurse was interviewed and stated resident was anxious to get off the floor and when she and the C.N.A were transferring the resident she lifted up her right leg and all her weight shifted to her left leg, that's the time when the C.N.A said for the resident to stand on both feet. The resident was assisted to bed with the nurse and C.N.A. and the nurse	

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	her voice at the resident. He indicated that he had not reported this to the Administrator or the Director of Nursing. Interview with the Director of Nursing on 10/17/12 at 4:20 p.m., indicated that she was not aware of the allegation of verbal abuse involving Resident #61. She also indicated the East Unit Manager should have reported this immediately to the Administrator when the resident's daughter voiced these concerns on 10/16/12. 3.1-28(c)		completed another head to toe assessment without findings. 2.The C.N.A. has not worked since 10/15/2012. The C.N.A has been terminated. The Unit Manager was suspended on 10/17/2012 and will be educated on Abuse and reporting abuse. All Residents that could complete a resident interview were interviewed on 10/17/2012 for any other allegations of abuse. Any resident that was not interviewable had a family interview conducted. Any findings were immediately reported to the ED for follow up. 3.In-servicing and education started on 10/17/2012 with all staff on Abuse, Responding to and investigating allegations of abuse at 17:45PM and will continue on all shifts until all staff are in-serviced. 4.The DNS / Designee will complete interviews with 60 residents or families quarterly as an ongoing practice of this facility to identify allegations of abuse and compliance with reporting and follow up. All findings will be reported in Monthly PI meeting for all findings. The SDC/Designee will in-service on Abuse policy and procedures with orientation and as needed.	

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F0226 SS=D	483.13(c) DEVELOP/IMPLMENT ABUSE/NEGLECT, ETC POLICIES The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property. Based on record review and interview, the facility failed to ensure the facility abuse policy was followed related to immediately reporting an allegation of verbal abuse to the Administrator for 1 of 3 allegations of abuse reviewed. (Resident #61) Findings include: Interview with Resident #61 on 10/16/12 at 1:54 p.m., indicated that CNA #4 had yelled at her the previous evening when she fell in the shower room. The resident indicated the CNA did not help her enough to transfer from the shower chair to the wheelchair and her leg gave out and she fell. The resident indicated the CNA yelled at her for not helping with the transfer. The resident and her daughter indicated they reported this to the East Unit Manager on 10/16/12. Interview with the East Unit Manager on 10/17/12 at 4:10 p.m., indicated that he met with the resident's	F0226	1.Residebt #61 reported to her daughter and ISDH that on 10/14/2012 after she had been assisted to the floor while transferring from the shower chair with the C.N.A. , the C.N.A. yelled at her. Resident #61's Daughter reported the concern to the Unit Manager on 10/16/2012. The unit manager failed to identify the concern as an allegation of abuse and report to the ED. ISDH surveyors notified the facility DNS on 10/17/2012 about the alleged abuse. The Facility Administration interviewed the resident and her daughter together on 10/17/2012 at 1730. Residnet #61 stated that the C.N.A. had yelled when the nurse and C.N.A. were transferring her to the Wheelchair from the floor and she lifted her right leg. Resident #61 stated she did not believe there was any intent of harm but she could no longer stand on her right leg during the transfer. Pain assessment completed with no findings. MD and daughter were notified of fall and care plan updated for 2 C.N.A.s with transfers in the shower. The Nurse was interviewed and stated resident was anxious to get off	11/22/2012

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	daughter on 10/16/12 related to care concerns from the previous evening. He indicated the resident and the resident's daughter did not want CNA #4 caring for the resident anymore. He also indicated the resident was lowered to the floor in the shower room the night before and there was some indication the CNA had raised her voice at the resident. He indicated that he had not reported this to the Administrator or the Director of Nursing. Interview with the Director of Nursing on 10/17/12 at 4:20 p.m., indicated that she was not aware of the allegation of verbal abuse involving Resident #61. She also indicated the East Unit Manager should have reported this immediately to the Administrator when the resident's daughter voiced these concerns on 10/16/12. The facility Abuse policy was reviewed on 10/17/12 at 3:00 p.m. The policy was provided by the Director of Nursing and identified as current. The Abuse policy indicated the following: "the center staff must report all alleged violations involving mistreatment, neglect, or abuse, including injuries of unknown source and misappropriation of resident		the floor and when she and the C.N.A were transferring the resident she lifted up her right leg and all her weight shifted to her left leg, that's the time when the C.N.A said for the resident to stand on both feet. The resident was assisted to bed with the nurse and C.N.A. and the nurse completed another head to toe assessment without findings. 2.The C.N.A. has not worked since 10/15/2012. The C.N.A has been terminated. The Unit Manager was suspended on 10/17/2012 and will be educated on Abuse and reporting abuse. All Residents that could complete a resident interview were interviewed on 10/17/2012 for any other allegations of abuse. Any resident that was not interviewable had a family interview conducted. Any findings were immediately reported to the ED for follow up. 3.In-servicing and education started on 10/17/2012 with all staff on Abuse, Responding to and investigating allegations of abuse at 17:45PM and will continue on all shifts until all staff are in-serviced. 4.The DNS / Designee will complete interviews with 60 residents or families quarterly as an ongoing practice of this facility to identify allegations of abuse and compliance with reporting and follow up. All findings will be reported in Monthly PI meeting for all findings. The SDC/Designee	

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	155218	A. BUILDING 00 B. WING	10/23/2012

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	property and are reported immediately to the administrator of the facility and to other officials in accordance with State law through established procedures (including to the State survey and certification agency)." 3.1-28(a)		will in-service on Abuse policy and procedures with orientation and as needed.	

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F0241 SS=D	483.15(a) DIGNITY AND RESPECT OF INDIVIDUALITY The facility must promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality. Based on observation, record review and interview, the facility failed to ensure staff knocked on the door prior to entering the resident's room as well as explaining to the resident what care they were going to provide. This affected 1 of 2 residents who met the criteria for dignity. The facility also failed to ensure a dignity bag was in use for 1 of 3 residents reviewed for the use of Foley (urinary) catheters. (Residents #32 and #180) Findings include: 1. On 10/16/12 at 10:26 a.m., CNA #5 entered Resident #180's room. The CNA did not knock prior to entering the resident's room. The CNA then proceeded to walk over to the side of the resident's bed and pull the blanket down, exposing the resident's arms. The CNA did not explain to the resident what he was going to do. The record for Resident #180 was reviewed on 10/18/12 at 8:33 a.m.	F0241	1.Resident #32 now has an indwelling Catheter bag cover. The C.N.A has been in-serviced on Dignity related to knocking on doors before entering the room and asking permission to move clothing or blankets. 2.All residents with an indwelling catheter have the potential to be affected. An audit of all residents with an indwelling catheter was completed and all catheter bags have a cover in place. All residents have the potential to be affected related to staff knocking on the door before entering and moving clothes or bedding without asking permission. 3.All staff have been in-serviced on Quality of Life with emphasis on covering catheter bags and treating the resident's private space and property with respect by knocking on doors before entering the room and asking permission to move or inspect personal clothes or bedding. 4.The DNS/Designee will interview 6 residents once a week for compliance with knocking on the door before entering and asking permission before removing clothes or bedding for 3	11/22/2012

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	The resident's diagnoses included, but were not limited to, traumatic brain injury and encephalopathy (brain disorder). Interview with the District Director of Clinical Operations (DDOC) on 10/18/12 at 9:00 a.m., indicated even though the resident was non-responsive, the CNA still should have knocked on the door prior to entering the resident's room and explained to him what he was going to do. 2. Resident #32 was observed on 10/16/12 at 10:10 a.m. He was seated in his room in a wheelchair. The resident had a Foley catheter (a tube inserted into the resident's bladder to drain urine) in place. The urinary drainage bag, attached to the Foley catheter, was hanging on the resident's wheelchair. The urine in the drainage bag was visible. The drainage bag was not in a dignity bag. The resident was observed on 10/22/12 at 11:18 a.m. The resident's catheter drainage bag was hanging from the side of the wheelchair. The drainage bag was not in a dignity bag and it did not have a cover on it. There was urine in the drainage bag that was visible.		months. The DNS/Designee will audit resident's indwelling catheters for dignity bag placement once weekly X 3 months, then monthly X 3 months. The DNS/Designee will complete observations of staff once a week for the next 3 months on each unit for knocking on doors and asking permission to remove clothes or bedding. The results of these audits will be tracked and reported to the PI committee monthly for 6 months or until 100% compliance is achieved as determined by the PI committee.	

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	The record for Resident #32 was reviewed on 10/22/12 at 10:38 a.m. The resident had diagnoses that included, but were not limited to, urinary obstruction and lung cancer. The Quarterly Minimum Data Set (MDS) assessment with an assessment reference date of 10/2/12, indicated the resident had an indwelling catheter in place. Interview with the South Unit Manager on 10/22/12 at 11:40 a.m., indicated the resident's urine drainage bag should have been covered or it should have been placed in a dignity bag so the urine was not visible. 3.1-3(t)			

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F0242 SS=D	483.15(b) SELF-DETERMINATION - RIGHT TO MAKE CHOICES The resident has the right to choose activities, schedules, and health care consistent with his or her interests, assessments, and plans of care; interact with members of the community both inside and outside the facility; and make choices about aspects of his or her life in the facility that are significant to the resident. Based on record review and interview, the facility failed to ensure 1 of 3 residents reviewed for choices of the 6 who met the criteria for choices were offered a choice between male and female caregivers related to showers. (Resident #10) Findings include: Interview with Resident #10 on 10/16/12 at 8:29 a.m., indicated that he had not had a shower in over a week. He indicated that he refuses, because he does not want the "young ladies" to give him a shower. He further indicated that staff made him sign a paper that he refused. The record for Resident #10 was reviewed on 10/17/12 at 9:10 a.m. The resident's Admission Minimum Data Set (MDS) assessment, dated 9/26/12, indicated that it was very important to the resident to choose between a tub bath, shower, bed	F0242	1. Resident #10 has had his request for male staff to provide his shower accommodated as allows or offer his shower when male C.N.A.s are on the schedule so he may have his preferences accommodated.2. All residents with a prefence on the gender of the staff providing their shower have the potential to be affected. All residents have been interviewed for bathing choices and their plan of care updated to reflect their choices. 3. Education has been completed with all Department heads, licensed nurses, and C.N.As on Quality of Life with emphasis on resident choices for bathing.4. The DNS/Designee will review resident’s choices for bathing on admission /readmission, Quarterly, annually and PRN to ensure choices are reasonably accommodated. This will be an ongoing practice of this facility. 60 Residents/family members will be interviewed quarterly for bathing choices and the results tracked and reported to the PI committee in monthly PI meeting for	11/22/2012

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	bath, or sponge bath. The MDS also indicated the resident needed limited assist of one person for personal hygiene. The plan of care, dated 9/28/12, for self care performance deficit, indicated the resident's strength was that he was able to verbally express needs and his choices and preferences were to be honored whenever possible. Review of the shower schedule on 10/17/12 on 3:26 p.m., indicated the resident was to receive his shower on Wednesday and Saturday evenings. The shower sheet, dated 10/6/12, indicated the resident refused his shower and documentation indicated the Social Worker also tried to encourage him. There was no documented reason for the refusal. The shower sheet, dated 10/13/12, indicated the resident again refused his shower. Interview with the East Unit Manager on 10/17/12 at 4:15 p.m., indicated the resident was very private and took care of himself, he assumed this was the reason the resident was refusing his showers. He was not aware the		compliance.	

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	resident did not want female CNA's giving him a shower. 3.1-3(u)(3)			

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F0247 SS=A	483.15(e)(2) RIGHT TO NOTICE BEFORE ROOM/ROOMMATE CHANGE A resident has the right to receive notice before the resident's room or roommate in the facility is changed. Based on record review and interview, the facility failed to ensure 2 of 2 residents who met the criteria for Admission, Transfer, and Discharge were given notice prior to room changes and receiving a roommate. (Residents #18 and #34) Findings include: 1. Interview with Resident #34 on 10/15/12 at 2:47 p.m., indicated that she had been moved to a different room in the facility within the past 9 months. The resident indicated her belongings were moved while she was at dialysis. The record for Resident #34 was reviewed on 10/19/12 at 2:02 p.m. An entry in the Nursing progress notes, dated 10/2/12 at 12:29 p.m., indicated the resident returned from dialysis and was transferred to Room 108-1. Interview with Social Service Staff Member #1 on 10/19/12 at 2:15 p.m., indicated there was no documentation to indicate if the resident had been	F0247	1.Resident # 34 was offered a room change related to the facility failing to notify her of a room change. Resident # 18 was offered a room change related to the facility failing to notify him of the new roommate. Both residents are satisfied with their rooms. 2.All residents with a room change or new roommate have the potential to be affected. Any resident in need of a room transfer or receiving a new roommate will be notified in advance and offered the opportunity to tour the room prior to a room move. Residents will be introduced prior to the room move. All room to room transfers will be documented and maintained in the medical record of the resident. 3. Education on Room-to-Room Transfers has been completed with all department heads and Licensed nurses. 4. The ED/Designee along with the SSD will sign the form for validation that the center discussed the transfer with the resident, family and/or responsible party in advance of the room transfer. The form will also be completed for validation that residents are introduced prior	11/22/2012

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	notified of her room change prior to 10/2/12. 2. Interview with Resident #18 on 10/16/12 at 10:28 a.m., indicated that she had not been notified of getting a new roommate, she indicated "you meet them when they are coming in." The record for Resident #18 was reviewed on 10/19/12 at 2:10 p.m. Documentation in the Nursing progress notes, indicated the resident had received a new roommate on 12/22/11. Interview with Social Service Staff Member #1 at the time, indicated there was no documentation to indicate if the resident had been notified prior to receiving her new roommate. 3.1-3(v)(2)		to a room move and signed by the SSD and ED/Designee prior to any transfers. This will be an ongoing practice of this facility. The Ed/Designee will complete once a week interviews with the resident or family for verification that notification of transfer was provided and introduction of new roommates for 4 transfers a month x 3 months, then once a month for 3 months all findings will be reported to the PI committee in monthly PI meeting until 100% compliance is determined by the PI committee.	

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F0248 SS=D	483.15(f)(1) ACTIVITIES MEET INTERESTS/NEEDS OF EACH RES The facility must provide for an ongoing program of activities designed to meet, in accordance with the comprehensive assessment, the interests and the physical, mental, and psychosocial well-being of each resident. Based on observation, record review and interview, the facility failed to ensure the resident's preferred activity of listening to music was provided for 1 of 1 residents reviewed for hospice services. (Resident #83) Findings include: Resident #83 was observed on 10/15/12 at 10:45 a.m., 12:40 p.m. and at 2:30 p.m. The resident was in bed and there was no music being played in the resident's room. The resident was observed on 10/16/12 at 8:19 a.m., 10:29 a.m., 11:20 a.m. and 1:30 p.m. The resident was in bed and there was no music in the resident's room. On 10/17/12 at 8:18 a.m., the resident was observed in bed. There was no music or television on for the resident. Continued observations throughout the day on 10/17/12 at 10:15 a.m.,	F0248	1.Resident #83 now has a radio with a CD player to play music in her room and her music preference has been added to her plan of care. 2.All residents preferring music to be played in their room have the potential to be affected. An audit has been completed of all current residents for identification of residents with preference for music in their room as an activity and their plan of care updated. 3.Education completed with all department heads, Activity department staff, licensed nurses and C.N.A.s on Activity Programs with emphasis on resident's preferences and providing supplies for activities, and assistance when needed for the activity. 4.The Activity Director/Designee will monitor residents with preferences for activities in the room once weekly for 3 months, then twice a month for 3 months to ensure compliance. 60 Residents will be interviewed Quarterly thereafter for preferences with in room activities and supplies to achieve the activity. All findings will be	11/22/2012

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	11:20 a.m., 12:21 p.m., 2:07 p.m. and 3:15 p.m., indicated the resident was in bed with the television on. Various talk shows and soap operas were observed on the television, but no musical television shows were on for the resident. The resident was observed on 10/18/12 at various times of the day. The resident was in bed with the television on at 8:24 a.m., 9:45 a.m. and 12:30 p.m. There was no music on the television. On 10/18/12 at 9:45 a.m., the resident's daughter was interviewed. She indicated the resident really liked to listen to music and she would appreciate music being provided for the resident. She indicated it was one of the few things the resident could still enjoy. The record for Resident #83 was reviewed on 10/17/12 at 1:13 p.m. The resident had diagnoses that included, but were not limited to, Huntington's chorea, dysphagia (difficulty swallowing) and hypertension. The resident had been on hospice services since 3/18/12. The Quarterly Minimum Data Set (MDS) assessment, dated 10/17/12,		reported to the PI committee monthly in the PI meeting until 100% compliance is achieved as determined by the PI committee.	

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	indicated the resident's "Preferences for Customary Routine and Activities" were, "receiving a bed bath, receiving a sponge bath, reading books, newspapers, or magazines, listening to music, being around animals such as pets, and participating in religious activities or practices." The residents care plan, which was not dated, indicated: Resident is on one to one program for in room visits and stimulation. The resident will be visited in her room at the bedside with one on one visits for stimulation and interaction with others through next review (strengths: pets, mass, music). The interventions included: Place activity calendar in resident room for reference. Activity staff to visit resident in room at bedside. Activity staff to offer a variety of sensory items such as reading to resident, offering sensory items, playing music for her and showing her pictures. Allow time for resident to give facial expressions or make eye contact and praise all resident's efforts. The Activity Progress note, dated 8/27/12, indicated, "The resident			

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	appears alert to person as when writer and activity staff call her name she will make eye contact. Resident's overall condition continues to decline physically, due to her diagnosis. Resident is visited in her room one on one at bedside. The activity staff and volunteers bring soothing music to play for resident. At times she will open her eyes and appears to listen. Resident is unable to share her thoughts she does make noises in response at times. Activity staff also use soothing lotion to help her relax. Activity staff read to resident from poetry book, devotional books and chicken soup for the soul with inspirational stories." Interview with the Activity Director on 10/15/12 at 8:48 a.m., indicated the resident does not have a radio or other device in her room for music. She indicated she has never asked family to bring in a radio. She also indicated that she had not asked family what type of music the resident enjoyed. She indicated the activity staff does play music for the resident at times during one on one visits but had not provided the resident with a device in her room to play music daily. She indicated the resident remains in her room most of the time and is isolated.			

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	Interview with Activity Aide #1 on 10/19/12 at 9:24 a.m., indicated she had gone into the resident's room on 10/15/12 and 10/16/12 and had turned the television on for her. She also indicated that she did perform a one on one activity with the resident and read to her. She indicated she did not provide any music for the resident 10/15/12 through 10/19/12. 3.1-33(a)			

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KINDRED TRANSITIONAL CARE AND REHABILITATION-DYER	2300 GREAT LAKES DR DYER, IN 46311

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F0278 SS=A	483.20(g) - (j) ASSESSMENT ACCURACY/COORDINATION/CERTIFIED The assessment must accurately reflect the resident's status. A registered nurse must conduct or coordinate each assessment with the appropriate participation of health professionals. A registered nurse must sign and certify that the assessment is completed. Each individual who completes a portion of the assessment must sign and certify the accuracy of that portion of the assessment. Under Medicare and Medicaid, an individual who willfully and knowingly certifies a material and false statement in a resident assessment is subject to a civil money penalty of not more than $1,000 for each assessment; or an individual who willfully and knowingly causes another individual to certify a material and false statement in a resident assessment is subject to a civil money penalty of not more than $5,000 for each assessment. Clinical disagreement does not constitute a material and false statement. Based on observation, record review and interview, the facility failed to ensure the Minimum Data Set (MDS) assessments were accurately completed for 1 of 1 residents reviewed for hospice services and for 1 of 2 residents reviewed for dental services of the 2 residents who met	F0278	1. Resident #62 and Resident #83 have had a their MDS modified and accurately coded for hospice services for resident # 62 and dental services for Resident #83.2. All residents with Hospice services and residents meeting criteria for dental services have the potential to be affected. An audit of all residents with Hospice	11/22/2012

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	the criteria for dental services. (Residents #62 and #83) Findings include: 1. Resident #62 was observed on 10/17/12 at 8:34 a.m. The resident was in a Broda chair and her mouth was open. There was a broken tooth on the lower portion of her mouth, the teeth in her mouth were discolored and were in poor condition. The record for Resident #62 was reviewed on 10/18/12 at 2:08 p.m. The resident had diagnoses that included, but were not limited to, dementia, hypertension and depression. There was a Nutritional Assessment, dated 9/12/12, that indicated the resident received pureed food and nectar thickened liquids. It also indicated in the "Oral Health" section that the resident had "caries and decay." The form titled "Patient Nursing Evaluation Part 3," dated 9/11/12, was reviewed. The form indicated the resident had "missing teeth" and "caries/decay." The Significant Change Minimum		services have had their MDS reviewed and any modifications needed submitted. All residents with the need for dental services have had their MDS audited and any with the need for a modified MDS to be completed have had the coding completed and MDS modification submitted.3. The MDS nurses have been in-serviced on accurate coding of the MDS for assessments. 4. The MDS Coordinator will audit completed MDS weekly before transmission for accuracy in coding for 3 months then monthly for 3 months. All findings will be reported in monthly PI for compliance and the Pi commitee will determine if further auditing is required or if 100% compliance has been achieved.	

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	Data Set (MDS) assessment with an assessment reference date of 9/26/12, was reviewed. It indicated the resident did not have obvious or likely cavity or broken natural teeth. Interview with MDS Coordinator #2 on 10/18/12 at 1:42 p.m., indicated the MDS was not accurately coded. 2. The record for Resident #83 was reviewed on 10/17/12 at 1:13 p.m. The resident had diagnoses that included, but were not limited to, Huntington's chorea and dementia. The resident had been admitted to hospice services on 3/18/12. The form titled "Physician's Certification for Medicare Hospice Benefit," dated 3/18/12, and signed by the Hospice Medical Director was reviewed. It indicated the resident had a terminal diagnosis of Huntington's chorea and dementia. The form also indicated Resident #83 was terminally ill with a life expectancy of six months or less if the terminal illness runs its normal course. The form titled "Physician's Certification for Medicare Hospice Benefit," dated 6/16/12, and signed by the Hospice Medical Director was			

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	reviewed. It indicated the resident had a terminal diagnosis of Huntington's chorea. It indicated the resident was terminally ill with a life expectancy of six months or less if the terminal illness runs its normal course. The Quarterly MDS with an assessment reference date of 5/29/12, was reviewed. It indicated the resident was not receiving hospice services and it did not indicate the resident had a condition or chronic disease that may result in a life expectancy of less than 6 months. The Quarterly MDS with an assessment reference date of 8/28/12, was reviewed. It did not indicate the resident had a condition or chronic disease that may result in a life expectancy of less than 6 months. Interview with MDS Coordinator #2 on 10/17/12 at 2:35 p.m., indicated the MDS assessment with the assessment reference dates of 5/29/12 and 8/28/12, were inaccurately coded related to the resident's life expectancy. She also indicated the MDS with an assessment reference date of 5/29/12, was inaccurately coded related to the resident receiving			

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	hospice services. 3.1-31(d)			

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F0279 SS=D	483.20(d), 483.20(k)(1) DEVELOP COMPREHENSIVE CARE PLANS A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care. The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The care plan must describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.25; and any services that would otherwise be required under §483.25 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(b)(4). Based on observation, record review and interview, the facility failed to ensure a care plan was initiated for 1 of 1 residents receiving dialysis services and for 1 of 3 residents of the 8 who met the criteria for skin conditions (non-pressure related). (Residents #34 and #52) Findings include: 1. On 10/16/12 at 1:42 p.m., Resident #52 was observed with areas of reddish/purple discoloration to his left and right forearms.	F0279	1. Resident #34 now has a care plan for dialysis. Resident # 52 had a current care plan for non-pressure skin condition (bruise). Resident #52 discharged home.2. All residents receiving dialysis services and all residents with bruises have the potential to be affected. An audit of all residents receiving dialysis services and bruises or the potential for bruises have had their care plans audited and any resident without a current care plan has had one initiated for dialysis monitoring and bruises and the potential for bruises.3. Education has been completed	11/22/2012

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	On 10/18/12 at 8:20 a.m., the resident was observed with a reddish/purple bruise to the top of his right hand. At 9:48 a.m., the resident was observed in his wheelchair in the hall. Reddish/purple bruising was observed to the top of his left and right hands. On 10/19/12 at 7:56 a.m., 8:55 a.m., and 1:00 p.m., the resident was again observed with areas of bruising to the top of his left and right hands. The record for Resident #52 was reviewed on 10/19/12 at 8:45 a.m. A Physician's order, dated 9/6/12, indicated the resident was to receive Plavix (a medication used to prevent blood clots) and Lovenox (a medication used to prevent blood clots) daily. Review of the resident's current plan of care indicated the resident did not have a care plan related to the potential for bruising. Interview with the East Unit Manager on 10/19/12 at 2:53 p.m., indicated the resident did not have a care plan related to the potential for bruising and one would be initiated.		with all licensed nurses for comprehensive care plans. 4. The DNS/Designee will audit care plans weekly x 3 months for implementation of care plans related to residents receiving dialysis and residents with the potential for bruises or bruises, then monthly x 3 months and with admission, significant change, and quarterly. All findings will be reported in monthly PI meetingand the PI commitee will determine at 6 months if further monitoring is required or 100% compliance has been achieved.	

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	2. The record for Resident #34 was reviewed on 10/18/12 at 2:22 p.m. The resident's diagnoses included, but was not limited to, renal failure. Review of the Admission Minimum Data Set (MDS) assessment, dated 8/7/12, indicated the resident was receiving dialysis. Review of the current 8/7/12 care plan, indicated there was no care plan related to monitoring the resident while receiving dialysis. Interview with the Director of Nursing on 10/19/12 at 12:47 p.m., indicated there was no care plan to monitor the resident while on dialysis 3.1-35(a)			

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F0282 SS=E	483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care. Based on observation, record review and interview, the facility failed to ensure physician's orders and/or the plan of care were followed as written related to fall prevention for 1 of 3 residents reviewed for accidents of the 11 who met the criteria for accidents, monitoring of skin conditions for 1 of 3 residents reviewed for skin conditions of the 8 who met the criteria for skin conditions (non-pressure related), dietary referrals for 2 of 3 residents reviewed for nutrition of the 6 who met the criteria for nutrition, weekly documentation of pressure areas for 1 of 3 residents reviewed for pressure ulcers of the 4 who met the criteria for pressure ulcers, and not getting a resident out of bed for 1 of 1 residents reviewed for hospice services. (Residents #32, #52, #53, #62, #83, and #211) Findings include: 1. The record for Resident #52 was reviewed on 10/19/12 at 8:45 a.m. The nutrition plan of care, dated	F0282	1. Resident # 52 has been discharged home. Resident #53 no longer has a pressure ulcer to the Left buttock. Resident #53 has a pressure ulcer to the Left foot and measurements are obtained weekly and care plan updated. Resident #211 has an MD order for double portions of protein at every meal.Resident #62 has an MD order to discontinue the dycem and alarm in the Broda chair. Care plan and C.N.A. assignment sheet have been updated to reflect the MD orders. Resident #83 has a care plan to offer to get resident up for each meal and honor resident preferences. The care plan and C.N.A. sheet have been updated to reflect the intervention to get resident up for meals if resident is agreeable. Resident #32 has a care plan for the potential for bruises related to anticoagualtion therapy.2. The center will review residents with weight loss for RD reccommendations, weights and re-weights, pressure ulcers for weekly measurements, MD orders for diet and accuracy with tray cards, fall interventions implemented, residents out of bed for meals per their	11/22/2012

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	9/12/12, indicated the resident had the potential for weight fluctuations related to diuretic (water pill) use and lower ill-fitting dentures. One of the interventions indicated to monitor and evaluate any weight loss, determine percentage lost, and follow facility protocol for weight loss (complete a re-weight if there was a 5 pound difference from the previous weight and notify the Registered Dietitian). Review of the resident's weight history indicated on 9/7/12, he weighed 138 pounds and on 9/13/12 he weighed 123.2 pounds. A 14.8 pound loss. There was no re-weight available for review. A Physician's order, dated 9/6/12, indicated the resident was receiving a regular diet. The only "Nutrition Services Note" available for review was dated 9/12/12, prior to the resident's weight loss. Interview with the East Unit Manager on 10/19/12 at 2:33 p.m., indicated residents were usually weighed weekly and if a discrepancy was noted, the Registered Dietitian (RD) was notified and it was up to her to ask for a re-weight. Interview with the RD and Dietary		preference, non-pressure monitoring for bruises and care plans for the potential of bruises to assess that the written plan of care is being implemented in accordance with MD orders and followed through. 3. Education with all Nursing staff, RDs, Dietary manager, Dietary staff on RD recommendations, weights and re-weights, monitoring of pressure ulcers and non-pressure skin conditions, Accidents and Supervision with emphasis on implementing fall interventions, ADL assistance and Care plans.4. The DNS/designee will meet with the RD weekly in a NAR meeting to review all weights and re-weights and for RD recommendations regarding implemention weekly as an ongoing practice of this facility. The RD/Dietary manger will complete a weekly tray card audit for accuracy x 3 months, then monthly for 3 months. The DNS/Designee will audit all pressure and non-pressure skin conditions for weekly monitoring and care plan implementation as an on going practice of this facility. The IDT will make rounds twice daily to ensure fall interventions are implemented and sign the C.N.A. sheet with each round and discuss in the AM IDT meeting. Care plans will be reviewed weekly for implementation related to MD orders, fall interventions, Pressure and Non-pressure	

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	Technician on 10/19/12 at 2:45 p.m., indicated they were not aware of the resident's weight loss and would look into it. 2. The record for Resident #53 was reviewed on 10/18/12 at 1:38 p.m. Review of the Admission Nursing Assessment dated 8/3/12, indicated the resident was admitted with a Stage 2 pressure ulcer to her left buttock that measured 7.5 centimeters (cm) x 4.0 cm. Review of the Weekly Pressure Ulcer Report, indicated no measurements for the left buttock wound were documented on 8/10 and 8/17/12. The current plan of care, indicated the resident had a pressure ulcer to her left plantar foot and a history of pressure ulcers. One of the interventions indicated to measure length, width, and depth of the pressure ulcers. Interview with the District Director of Clinical Operations on 10/23/12 at 3:00 p.m., indicated the resident no longer had the pressure area to the left buttock. She further indicated the pressure ulcer to the left buttock should have been measured weekly. 3. On 10/17/12 at 9:00 a.m.,		monitoring x 3 months then monthly, on admission, quarterly, and with significant change. All findings will be reviewed in monthly PI meeting for 6 months and the PI commitee will determine any required monitoring needed to achieve 100% compliance.	

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	Resident #211 was observed eating breakfast in the Main Dining room. The resident was served one waffle, a bowl of hot cereal, and 2 sausage links. The resident did not receive double portions of protein. On 10/17/12 at 12:48 p.m., the resident was observed eating lunch in the Main Dining room. The resident was served one cup of ice cream, a cup of pudding, a regular portion of turkey a la king, seven green beans, and one biscuit. On 10/18/12 at 8:07 a.m., the resident was observed in the Main Dining room waiting on breakfast. At 8:34 a.m., she was served one serving of scrambled eggs, one piece of toast and one bowl of hot cereal. The resident did not receive double portions. The record for Resident #211 was reviewed on 10/17/12 at 8:28 a.m. The resident was admitted to the facility on 6/20/12 from the hospital. The resident's diagnoses included, but were not limited to, muscle weakness, difficulty in walking, atrial fibrillation, high blood pressure and osteoporosis. Review of Physician Orders on the			

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	current 10/12 recap, indicated the resident was to receive double portions of protein at every meal. Review of the Dietary progress note, dated 7/26/12, indicated the recommendation by the Registered Dietitian was to serve the resident double portions of protein at all meals. Interview with the Dietary Food Manager on 10/18/12 at 8:40 a.m., indicated he was not aware the resident was to receive double portions of protein at all meals. 4. Resident #62 was observed on 10/17/12 at 8:34 a.m. She was seated in a Broda chair. The resident had a self releasing seat belt around her waist with the buckle in the front of her. There was no pull tab alarm attached to the resident. The resident was observed on 10/17/12 at 10:30 a.m., she was seated in a Broda chair in the West Unit dining room. She had a self release belt on. There was no pull tab alarm attached to the resident. On 10/17/12 at 12:40 p.m., the resident was in the Broda chair in the dining room. There was no pull tab			

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	alarm attached to the resident. There was a self release seat belt in place. The resident was observed on 10/17/12 at 3:20 p.m., she was seated in the Broda chair in front of the Nurses' Station. There was a self release seat belt in place. There was no pull tab alarm attached to the resident. On 10/18/12 at 8:15 a.m., the resident was up in the Broda chair with a self release seat belt in place. There was no pull tab alarm in place. On 10/18/12 at 1:55 p.m., the resident was observed being transferred from the Broda chair to the bed by CNA #1 and CNA #2. The self release seat belt was on the resident. There was no Dycem (a material to prevent the resident from sliding) in the chair under the resident and there was no pull tab on the chair attached to the resident. Interview with CNA #1 on 10/18/12 at 1:55 p.m., indicated there was no Dycem and no pull tab alarm on the resident. Continued interview with CNA #1, indicated she had not applied the pull tab alarm since the seat belt was applied.			

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KINDRED TRANSITIONAL CARE AND REHABILITATION-DYER	2300 GREAT LAKES DR DYER, IN 46311

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	CNA #1 had the West Unit CNA Assignment Sheet in her pocket. On 10/18/12 at 1:55 p.m., the CNA assignment sheet was reviewed. It indicated the resident was to have a low bed with a mat at the bedside, a self release belt, a pressure alarm to the bed, a pull tab to chair, a cushion with Dycem, and a foot buddy to the Broda chair. The record for Resident #62 was reviewed on 10/18/12 at 2:08 p.m. The resident had diagnoses that included, but were not limited to, dementia, macular degeneration and seizures. There was a Physician's Order, dated 9/11/12, that indicated the resident was to use a self-releasing seat belt. There was a Falls Care Plan with a revision date of 9/20/12, that indicated the resident was at risk for falls due to unsteady gait, psychoactive drug use, poor communication/comprehension, disease process condition, and dementia. The interventions to be used to prevent falls were: -Broda chair for proper positioning -concave mattress to bed -Dycem to Broda chair			

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	-low bed with mat next to bed -pressure alarm to bed -pull tab alarm to wheelchair -self release wheelchair belt to Broda chair The October 2012 Physician Order Sheet, indicated the resident was to have a pull tab alarm to the wheelchair and a wheelchair cushion with Dycem. The resident had a fall on 10/5/12. Review of the "Post Fall Evaluation Part 1" form, did not indicate the resident had the self release belt on at the time of the fall. Interview with the West Unit Manager on 10/18/12 at 2:15 p.m., indicated the resident did not have a self release belt on, as ordered by the Physician, at the time of the fall on 10/5/12. She indicated the resident was gotten up by a Hospice CNA who did not place the seat belt on the resident. She also indicated facility staff did not apply the seat belt after Hospice staff left. The form titled (Name of Hospice Company) Hospice "Incident Report Tracking Form," dated 10/5/12, was reviewed. It indicated, "Staff at (Facility's Name) Nursing facility			

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	stated that patient fell from Broda chair striking her head, resulting in need for emergency hospital visit. Our HHA (Home Health Aide) had gotten patient up at 7:15 a.m., did care, and when she left facility, patient was fully reclined in Broda and next to the Nurses' station. The fall occurred at approximately 11:00 a.m. The seat belt was not fastened/secured and was underneath patient." Interview with the West Unit Manager on 10/18/12 at 2:30 p.m., indicated the resident had Physician's Orders for a pull tab alarm and for Dycem in the chair. She indicated the fall devices were not in place as ordered during observations on 10/17/12 and 10/18/12. She indicated the devices should have been in place. 5. Resident #83 resided on the South Unit. She was observed on 10/15/12 at 10:45 a.m., 12:40 p.m. and at 2:30 p.m. The resident was in bed in her room. The resident was observed on 10/16/12 at 8:19 a.m., 10:29 a.m., 11:20 a.m. and 1:30 p.m. The resident was in bed. At 8:19 a.m., the residents on the South Unit were eating breakfast in the dining room.			

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	On 10/17/12 at 8:18 a.m., 10:15 a.m., 11:20 a.m., 12:21 p.m., 2:07 p.m. and 3:15 p.m., the resident was observed in bed. At 12:21 p.m., the residents on the South Unit were eating lunch in the dining room. The resident was observed on 10/18/12 at various times of the day. The resident was in bed at 8:24 a.m., 9:45 a.m. and 12:30 p.m. At 8:24 a.m.,the residents on the South Unit were eating breakfast in the dining room. At 12:30 p.m., the residents on the South Unit were eating lunch in the dining room. On 10/19/12 at 8:12 a.m., the residents on the South Unit were in the dining room being served breakfast. Resident #83 was in bed. The record for Resident #83 was reviewed on 10/17/12 at 1:13 p.m. The resident had diagnoses that included, but were not limited to, Huntington's chorea, dysphagia (difficulty swallowing) and hypertension. The October 2012 Physician Order Sheet, indicated the resident was to be up as tolerated, not for greater than 2 hours per family request.			

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	The Care Plan that was revised on 2/28/12, indicated the resident required extensive assist with adl's (activities of daily living) due to the diagnosis of Huntington's chorea. Some of the interventions were: -extensive assist with bed mobility, transfers, bathing, and hygiene -up for all meals -assist resident out of bed when she wakes up as soon as possible The South Unit CNA (Certified Nursing Assistant) assignment sheet was reviewed. It indicated the resident was to be, "up for all meals." Review of the progress notes dated 10/13/12 through 10/19/12, indicated there was no evidence that the resident had refused to get out of bed. Interview with the South Unit Manager on 10/19/12 at 8:29 a.m., indicated the resident had not been up in the Broda chair and had not been up for meals 10/15/12 through 10/18/12. She indicated the staff should have gotten the resident out of bed as indicated on the resident's care plan. 6. Resident #32 was observed on 10/16/2012 at 10:09 a.m. The			

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	resident had a bruise on the back of his right hand 1 and 1/2 inches in size. On 10/22/12 at 11:17 a.m., the resident was observed in his room seated in the wheelchair. There was a fading bruise on the back of his right hand. There was a bruise on the inside of his left forearm that was a 1/2 inch in diameter and was purple in color. The record for Resident #32 was reviewed on 10/22/12 at 10:38 a.m. The resident had diagnoses that included, but was not limited to, lung cancer. There was a Care Plan, dated 10/4/12, that indicated the resident was at risk for abnormal bleeding or hemorrhage due to anticoagulant (medications that reduce the risk of blood clots) use related to Coumadin (a blood thinner) therapy. The interventions were: - medications as ordered -monitor for and report to nurse any of the following signs and symptoms of bleeding: bleeding gums, nose bleeds, unusual bruising, tarry/black stools, pink or discolored urine -monitor for signs and symptoms of			

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	bleeding (bruising, ecchymosis, epistaxis)(nose bleed) The October 2012 Physician Order Sheet, indicated the resident was receiving Coumadin 8 mg (milligrams) every other day alternating with Coumadin 7.5 mg every other day. The "Weekly Skin Check" form completed on 10/16/12, indicated there were no non-pressure skin concerns. The resident was discharged to the hospital on 10/17/12 at 7:01 a.m. The resident was readmitted to the facility on 10/19/12. The "Skin Inspection Anatomy Diagram" form, dated 10/20/12, indicated the resident had no open areas and no non-pressure areas. The "Patient Nursing Evaluation" form, dated 10/19/12, upon readmission to the facility, indicated the resident's skin was supple, normal and free from open areas. Interview with LPN #2 on 10/22/12 at 11:31 p.m., indicated when a bruise was noted it was to be documented on the "Non-Pressure Skin Condition" form and it was to be monitored			

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	weekly until resolved. She also indicated when a resident was admitted or readmitted to the facility, the nurse was to do a skin inspection assessment and was to document the findings on the "Patient Nursing Evaluation" form. There was no evidence the bruise on the back of the resident's right hand and the bruise that was on the resident's left forearm was assessed and monitored before discharge to the hospital and upon return from the hospital. There was no evidence that the care plan to "monitor for signs and symptoms of bleeding such as bruising" was being followed. LPN #2 completed "Weekly Non-Pressure Skin Condition Reports" for the resident on 10/22/12 at 12:35 p.m. She indicated the resident had a bruise on his left forearm that was 1.3 cm x 1.2 cm (centimeters) in size and was purple in color. She also indicated the resident had a bruise on the back of his left forearm that was 3 cm x 3.2 cm in size. Interview with LPN #2 on 10/22/12 at 2:45 p.m., indicated the resident had a bruise on the back of his right hand and on his left forearm. She indicated			

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	the areas should have been assessed and monitored as indicated by the resident's care plan. Interview with the South Unit Manager on 10/23/12 at 9:10 a.m., indicated residents receiving anticoagulant therapy need to be monitored for bruises, she indicated the resident's plan of care was not followed. 3.1-35(g)(2)			

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F0309 SS=E	483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care. Based on observation, record review and interview, the facility failed to provide the necessary treatment and services related to assessing a resident prior to and after receiving dialysis for 1 of 1 residents reviewed for dialysis. The facility also failed to assess and monitor skin conditions for 3 of 3 residents reviewed for skin conditions of the 8 who met the criteria for skin conditions (non-pressure related). (Residents #32, #34, #52 and #57) Findings include: 1. On 10/16/12 at 1:42 p.m., Resident #52 was observed with areas of reddish/purple discoloration to his left and right forearms. On 10/18/12 at 8:20 a.m., the resident was observed with a reddish/purple bruise to the top of his right hand. At 9:48 a.m., the resident was observed in his wheelchair in the hall. Reddish/purple bruising was	F0309	1. Resident #34 had no adverse effect. Resident #34 is being assessed and monitored prior to and after receiving dialysis. Resident #32, and 57 have a weekly non pressure sheet completed for their non-pressure areas. Resident #52 has discharged home.2. All residents receiving dialysis have the potential to be affected. All residents receiving dialysis have a Pre/Post Hemodialysis flow sheet in place to document pre and post dialysis assessments and a binder for communication with the dialysis center to be maintained with each dialysis service. All residents with non-pressure skin conditions have the potential to be affected. A head to toe skin assessment has been completed weekly of all residents with any non-pressure areas have been documented and will be monitored weekly until resolved.3. Education has been completed with nursing staff on dialysis communication with the centers and Pre/Post assessments. Education has been provided with all nursing	11/22/2012

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	observed to the top of his left and right hands. On 10/19/12 at 7:56 a.m., 8:55 a.m., and 1:00 p.m., the resident was again observed with areas of bruising to the top of his left and right hands. The record for Resident #52 was reviewed on 10/19/12 at 8:45 a.m. A Physician's order, dated 9/6/12, indicated the resident was to receive Plavix (a medication used to prevent blood clots) and Lovenox (a medication used to prevent blood clots) daily. Review of the resident's current plan of care at this time, indicated the resident did not have a care plan related to the potential for bruising. The Weekly Skin Assessments, dated 9/20, 9/27, 10/4, 10/11, and 10/18/12, indicated the resident had no bruises, lesions or skin tears. Review of the Skin inspection section of the Patient Nursing Evaluation Part 1, dated 9/6/12, indicated the resident had a surgical incision to his left hip area, no areas of bruising were documented.		staff on non-pressure skin conditions and monitoring.4. The DNS/Designee will audit weekly x 3months any resident receiving dialysis for pre/post assessments and communication with the dialysis centers, then every other week for 3 months. All findings will be reported in the monthly PI meeting and the PI commitee will then determine if further monitoring is needed or when 100% compliance is achieved. The DNS/Designee will assess all admissions and readmissions for non-pressure skin conditions and accurate documentation X 3 months. The DNS/Unit Manager will review all weekly skin assessments for accuracy and completion of weekly non-pressure skin documentation X 3 months, and continue to monitor non-pressure skin conditions weekly as an on-going practice of this facility. All findings will be reported in the monthly PI meeting and the PI commitee will determine if further monitoring needs to be completed or when 100% compliance is achieved after 6 months.	

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	Interview with the East Unit Manager on 10/19/12 at 2:53 p.m., indicated that a skin assessment was to be completed upon admission. He further indicated when any type of bruising or skin tears were observed, a non pressure skin sheet was to be initiated. The East Unit Manager was not aware of the areas to the top of the resident's left and right hands and indicated he would look into it. Further record review on 10/22/12 at 9:00 a.m., indicated a care plan related to the potential for bruising was initiated on 10/19/12 and a Physician's order was obtained on 10/19/12 at 3:31 p.m., to monitor the bruising to both hands daily until healed. On 10/19/12 at 3:25 p.m., the East Unit Manager initiated a "Weekly Non-pressure Skin Condition" report which indicated the resident had a bruise to the top of the left hand that measured 3 centimeters (cm) x 4.0 cm and two bruises to the top of the right hand that measured 2 cm x 2 cm and 6 cm x 4 cm. 2. On 10/18/12 at 1:55 p.m., Resident #34 was observed seated in a geri recliner in front of the Nurses' station. She indicated at that time,			

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	that she goes to dialysis every Tuesday, Thursday, and Saturday. She further indicated they pick her up around 5:00 a.m., and she returns to the facility between 10:00 and 10:30 a.m. The record for Resident #34 was reviewed on 10/18/12 at 2:22 p.m. The resident was admitted to the facility on 7/30/12 from the hospital. Prior to her hospitalization she was residing in another long term care facility. The resident's diagnoses included, but were not limited to, diabetes, anemia, high blood pressure, renal failure, and hypercholestremia. Review of the dialysis communication record folder, indicated the dialysis communication papers available for review were dated 9/17, 9/4, 8/28, 8/7, and 8/2/12. There were no other communication forms completed. Review of the above mentioned forms, indicated the dialysis center's portion was only completed. The facility's portion was incomplete. Further review of the dialysis communication sheets, indicated the resident's blood pressure, pulse and respirations were to be taken prior to leaving for the dialysis center. There			

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	was also a section on the communication form to describe the resident's condition or if the resident had any problems. Review of the vital signs, indicated the resident's blood pressure was documented on 8/1, 8/8, and 10/1/12. There was no other documentation of the resident's blood pressure in the clinical record. Review of Nursing Progress Notes for the month of October 2012, indicated there was no evidence of any documentation the resident was monitored or assessed prior to going and returning from the dialysis center. There was no current plan of care available for review. Review of the current 10/09 "Residents Receiving Dialysis" policy provided by the Director of Nursing, indicated "Licensed nurses evaluate the residents for signs and symptoms of infection/bacteremia, bleeding and/or hemorrhage, septic shock and/or excess/deficient fluids. Licensed nurses manage dialysis access site to maintain patency and adequate blood flow for dialysis. The plan of care includes the directives for managing the resident's needs for			

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	end stage renal disease." Review of the current 10/09 "Hemodialysis" policy provided by the Director of Nursing, indicated pre dialysis, licensed staff were to evaluate the vascular access site, communicate to the dialysis center the resident's medications taken in the last six hours, the last meal, and any changes or information in the resident's condition. Post dialysis, licensed staff were to assess the access site for patency and any unusual redness, check access site for bleeding, redness and swelling. Interview with LPN #4 on 10/19/12 at 11:00 a.m., indicated there was no place on the resident's Treatment Administration Record (TAR) or the Medication Administration Record (MAR) to document the assessment of the access site on a daily basis. Interview with the Director of Nursing on 10/19/12 at 12:47 p.m., indicated the facility's policy regarding dialysis was to assess the site daily and before the resident goes to dialysis. She further indicated there was no evidence of an assessment and vital signs documented prior to and post dialysis. 3. Resident #32 was observed on			

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	10/16/2012 at 10:09 a.m. The resident had a bruise on the back of his right hand 1 and 1/2 inches in size. On 10/22/12 at 11:17 a.m., the resident was observed in his room seated in the wheelchair. There was a fading bruise on the back of his right hand. There was a bruise on the inside of his left forearm that was a 1/2 inch in diameter and was purple in color. The record for Resident #32 was reviewed on 10/22/12 at 10:38 a.m. The resident had diagnoses that included, but was not limited to, lung cancer. There was a Care Plan that was dated 10/4/12, that indicated the resident was at risk for abnormal bleeding or hemorrhage due to anticoagulant (medications that reduce the risk of blood clots) use related to Coumadin (a blood thinner) therapy. The interventions were: - medications as ordered -monitor for and report to nurse any of the following signs and symptoms of bleeding: bleeding gums, nose bleeds, unusual bruising, tarry/black			

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	stools, pink or discolored urine -monitor for signs and symptoms of bleeding (bruising, ecchymosis, epistaxis) The October 2012 Physician Order Sheet, indicated the resident was receiving Coumadin 8 mg (milligrams) every other day alternating with Coumadin 7.5 mg every other day. The "Weekly Skin Check" form completed on 10/16/12, indicated there were no non-pressure skin concerns. The resident was discharged to the hospital on 10/17/12 at 7:01 a.m. The resident was readmitted to the facility on 10/19/12. The "Skin Inspection Anatomy Diagram" form, dated 10/20/12, indicated the resident had no open areas and no non-pressure areas. The "Patient Nursing Evaluation" form, dated 10/19/12, upon readmission to the facility, indicated the resident's skin was supple, normal and free from open areas. Interview with LPN #2 on 10/22/12 at 11:31 p.m., indicated that when a bruise was noted it was to be			

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	documented on the "Non-Pressure Skin Condition" form and it was to be monitored weekly until resolved. She also indicated when a resident was admitted or readmitted to the facility the nurse was to do a skin inspection assessment and was to document the findings on the "Patient Nursing Evaluation" form. There was no evidence the bruise on the back of the resident's right hand and the bruise that was on the resident's left forearm was assessed and monitored before discharge to the hospital and upon return from the hospital. LPN #2 completed "Weekly Non-Pressure Skin Condition Reports" for the resident on 10/22/12 at 12:35 p.m. She indicated the resident had a bruise on his left forearm that was 1.3 cm x 1.2 cm (centimeters) in size and was purple in color. She also indicated the resident had a bruise on the back of his left forearm that was 3 cm x 3.2 cm in size. Interview with LPN #2 on 10/22/12 at 2:45 p.m., indicated the resident had a bruise on the back of his right hand and on his left forearm. She indicated the areas should have been assessed			

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	when they were first observed by staff. 4. Resident #57 was observed on 10/15/12 at 1:55 p.m. The resident had 2 fading bruises noted on the left forearm. On 10/17/12 at 9:04 a.m., the resident was up in a Broda chair. He had a one inch in diameter bruise on the back of his left hand. The record for Resident #57 was reviewed on 10/17/12 at 8:47 a.m. The resident had diagnoses that included, but were not limited to, diabetes, dementia and Parkinson's disease. The October 2012 Physician Order Sheet, indicated the resident received 325 milligrams (mg) of aspirin daily. Review of the "Weekly Skin Check" sheets, dated 10/8/12 and 10/15/12, indicated the resident had no skin conditions or changes, no ulcers, or injuries. Interview with LPN #1 on 10/17/12 at 10:30 a.m., indicated when a bruise or skin tear was noted, it was to be documented on the "Weekly Non-pressure Skin Condition" form.			

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	She indicated it was then monitored weekly until it was resolved. Interview with LPN #1 on 10/17/12 at 2:40 p.m., indicated the resident did have a discolored area on the back of his left hand. She indicated when it was first noted, it should have been assessed and documented. The policy titled, "Pressure Ulcer/Non-Pressure Ulcer Assessment" with a revision date of 8/31/12, was provided by the Minimum Data Set (MDS)Coordinator #2 on 10/19/12. She indicated the policy was current. The policy indicated, "Pressure ulcer/non-pressure ulcer assessment is completed at least weekly to determine the progress of healing, the presence of possible complications (e.g. signs of increase in area of ulceration or soft tissue infection), the presence of pain (e.g., is it being adequately controlled,) and the status of the area surrounding the ulcer (that can be observed without removing the dressing)." Review of the Nursing Progress Note, dated 10/17/12 at 1:41 p.m., indicated, "Writer informed by unit manager of discoloration to posterior left hand and left posterior forearm."			

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	There was a care plan initiated on 10/17/12 that indicated: -ecchomysis (bruising) spots to left posterior hand, -areas to resolve thru next review -monitor for pain -monitor for skin integrity -notify MD of changes The "Weekly Non-pressure Skin" assessment, dated 10/17/12, indicated there was a non-pressure area to the back of the resident's left hand that was 1.5 centimeters (cm) x 1.2 cm in size and was purple in color. Interview with the South Unit Manager on 10/23/12 at 9:10 a.m., indicated the bruises noted on the resident's arms were not assessed when first identified by staff. She also indicated the resident's bruises were not monitored weekly. 3.1-37(a)			

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F0312 SS=D	483.25(a)(3) ADL CARE PROVIDED FOR DEPENDENT RESIDENTS A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene. Based on observation, record review and interview, the facility failed to ensure dependent residents were transferred out of bed for 1 of 1 residents reviewed for hospice services. (Resident #83) Findings include: Resident #83 resided on the South Unit. She was observed on 10/15/12 at 10:45 a.m., 12:40 p.m. and at 2:30 p.m. The resident was in bed in her room. The resident was observed on 10/16/12 at 8:19 a.m., 10:29 a.m., 11:20 a.m. and 1:30 p.m. The resident was in bed. At 8:19 a.m., the residents on the South Unit were eating breakfast in the dining room. On 10/17/12 at 8:18 a.m., 10:15 a.m., 11:20 a.m., 12:21 p.m., 2:07 p.m. and 3:15 p.m., the resident was observed in bed. At 12:21 p.m., the residents on the South Unit were eating lunch in the dining room.	F0312	1. Resident #83 is offered to be out of bed for 3 meals a day per her preference. 2. All residents dependent on staff for transfers to get out of bed have the potential to be affected. All C.N.A. sheets have been updated to reflect when dependent residents are to be out of bed. The DNS/Designee will complete twice daily rounds to ensure all dependent residents are assisted up out of bed per plan of care.3. Education has been completed with nursing staff on Activities of Daily Living.4. The DNS/Designee will complete twice daily rounds to ensure residents dependent on staff for transfers to get out of bed are assisted out of bed per plan of care x 5 days a week for 3 months, then daily x 3 months. All findings will be reported in the monthly PI meeting and the PI commitee will determine if 100% compliance has been achieved or if furhter monitoring is required.	11/22/2012

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The resident was observed on 10/18/12 at various times of the day. The resident was in bed at 8:24 a.m., 9:45 a.m. and 12:30 p.m. At 8:24 a.m., the residents on the South Unit were eating breakfast in the dining room. At 12:30 p.m., the residents on the South Unit were eating lunch in the dining room.

On 10/19/12 at 8:12 a.m., the residents on the South Unit were in the dining room being served breakfast. Resident #83 was in the bed.

The record for Resident #83 was reviewed on 10/17/12 at 1:13 p.m. The resident had diagnoses that included, but were not limited to, Huntington's chorea, dysphagia (difficulty swallowing) and hypertension. The resident had been on hospice services since 3/18/12.

The October 2012 Physician Order Sheet, indicated the resident was to be up as tolerated, not for greater than 2 hours per family request.

The Quarterly Minimum Data Set (MDS) assessment with an assessment reference date of 8/28/12, indicated the resident was

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	severely impaired in her decision making ability and required extensive assistance of 2 staff members for transfers. The Care Plan that was revised on 2/28/12, indicated the resident required extensive assist with adl's (activities of daily living) due to the diagnosis of Huntington's chorea. Some of the interventions were: -extensive assist with bed mobility, transfers, bathing, and hygiene -up for all meals -assist resident out of bed when she wakes up as soon as possible The Care Plan, dated 10/8/12, indicated the resident had an adl self care performance deficit related to the need for assistance with adl completion secondary to muscular skeletal impairment. The interventions included: - honor (resident's name) choices and preferences whenever possible -limit time up in Broda chair to no more than 2 hours per family request The South Unit CNA (Certified Nursing Assistant) assignment sheet was reviewed. It indicated the resident was to be, "up for all meals." Review of the progress notes, dated			

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	10/13/12 through 10/19/12, indicated there was no evidence the resident had refused to get out of bed. On 10/19/12 at 8:25 a.m., LPN #3 was interviewed. She indicated the resident will refuse to get out of bed. She indicated the resident would flail her arms and become agitated when staff attempted to get her out of bed. On 10/19/12 at 8:26 a.m., LPN #3 entered the resident's room. LPN #3 asked the resident if she desired to get up. The resident mumbled, "yes". The resident was observed up in a Broda Chair on 10/19/12 at 9:38 a.m. She was on the West Unit, outside of the dining room. An activity was being set up in the dining room. The resident was calm and there was no evidence of agitation noted. The resident was not flailing her arms. Observation of the resident on 10/19/12 at 10:30 a.m., indicated the resident remained up in the Broda chair. The resident was reclining in the chair, there were no signs of agitation noted, her eyes were closed and she was resting. Interview with the South Unit Manager on 10/19/12 at 8:29 a.m., indicated			

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	the resident had not been up in the Broda chair and had not been up for meals 10/15/12 through 10/18/12. She indicated the staff should have gotten the resident out of bed. 3.1-38(a)(2)(B)			

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F0314 SS=D	483.25(c) TREATMENT/SVCS TO PREVENT/HEAL PRESSURE SORES Based on the comprehensive assessment of a resident, the facility must ensure that a resident who enters the facility without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates that they were unavoidable; and a resident having pressure sores receives necessary treatment and services to promote healing, prevent infection and prevent new sores from developing. Based on observation, record review and interview, the facility failed to ensure nutritional interventions based on the status of a resident's pressure ulcer were implemented in a timely manner for 1 of 3 residents of the 4 who met the criteria for pressure ulcers. (Resident #53) Findings include: On 10/17/12 at 8:17 a.m., Resident #53 was observed with a gauze dressing to her left foot that was dated 10/16/12. On 10/18/12 at 12:50 p.m., the resident had pressure reduction boots in place to both feet. On 10/22/12 at 11:40 a.m., the resident was wearing a pressure reduction boot on her left foot.	F0314	1. Resident #53 has all RD recommendations oredered and implemented. 2. All residnets with a pressure ulcer and a nutritional intervention recommended by the RD have the potential to be affected. All residents with a pressure ulcer have been reviewed to ensure RD recommendations for nutritional interventions are implemented. 3. Education has been completed with licensed nurses and nursing managers on implementation of nutritional interventions timely.4. The DNS/Designee will review, with the RD ,weekly in the NAR meeting for weekly implementation of all nutritional recommendations as an on going practice of this facility and sign the weekly RD nutritional recommendations sheet to verifiy completion. All findings will be reported in the monthly PI meeting and the PI commitee will determine if 100% compliance	11/22/2012

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	On 10/23/12 at 2:55 p.m., the dressing to the resident's left foot was removed. The resident was observed to have sutures to the left plantar aspect of her foot. Interview with LPN #7 at the time, indicated the resident's foot had been sutured close by the Physician to aid in healing. She indicated the area was approximately the size of a dime prior to being sutured close. The record for Resident #53 was reviewed on 10/18/12 at 1:38 p.m. The resident's diagnoses included, but were not limited to, history of pneumonia, respiratory failure, tracheostomy, and gastrostomy (a tube that is inserted into the stomach). A nutrition services note, dated 9/25/12, indicated the resident was seen for significant weight loss at 10.7% times 1 month and multiple impaired skin areas. A recommendation was made to increase the resident's tube feeding of Glucerna 1.2 to 1 can, 6 times a day. Continue flushes as ordered. Documentation in the nutrition services notes, dated 10/1/12, indicated the resident was seen by		has been achieved or if furhter monitoring is required.	

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	nutrition services related to low protein and albumin levels. The resident continued to have a Stage 4 pressure ulcer to the foot. Other area to back healed. Medications include Vitamin C and multi-vitamin. Concur with prior recommendation to increase Glucerna 1.2 to 6 cans/day. Documentation completed by the Registered Dietitian (RD) on 10/6/12, indicated the following: "RD review for weight loss -12 lbs/12.3% in 1 month/14.2 lbs/14.9% times 2 months. Loss is significant, continues with Stage 4 to foot, currently receiving antibiotic for wound infection. Infection, along with wound could increase caloric needs. Resident NPO (nothing by mouth) with tube feed of Glucerna 1.2, 5 cans a day. Recommendation to increase tube feed to 6 cans a day made 9/25 and 10/1/12. No notice if MD agreed or disagreed with RD recommendation. Per NAR (nutrition at risk) notes, nursing states resident will at times refuse a feeding. RD unable to verify same per med sheets due to illegibility. No residuals noted per nursing notes. Please verify actual volume of tube feed administered. If verified that resident is not receiving 5 cans day, could be contributor for weight loss. If verified			

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	resident is not tolerating current prescribed volume, may want to consider 1.5 calorie feeding." A nutrition services note completed 10/10/12, indicated the reason for the visit was based on a conversation with the Nurse Practitioner, the resident's albumin was low at 2.8, also spoke with nurse who stated resident was not refusing feedings. Phone consult with RD, recommend change feedings to Jevity bolus 1 can 5 times a day, add promod (a protein supplement) 1 scoop twice a day through the gastrostomy tube. A Physician's order, dated 10/12/12, indicated to change the feeding formula to Jevity 1.5-1 can bolus 5 times daily. Continue same flush orders. Begin promod 30 milliliters (ml) twice a day. Interview with the District Director of Clinical Operations on 10/23/12 at 3:00 p.m., indicated the dietary recommendations should have been followed- up on in a more timely manner. 3.1-40(a)(2)			

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F0315 SS=D	483.25(d) NO CATHETER, PREVENT UTI, RESTORE BLADDER Based on the resident's comprehensive assessment, the facility must ensure that a resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; and a resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore as much normal bladder function as possible. Based on observation, record review, and interview, the facility failed to ensure there was a medical justification for the continued use of a Foley (urinary) catheter for 2 of 3 residents of the 3 who met the criteria for urinary catheters. (Residents #53 and #165) Findings include: 1. Interview with LPN #8 on 10/15/12 at 2:04 p.m., indicated Resident #53 had a Foley catheter in place due to having a Stage 2 pressure ulcer to her coccyx. On 10/17/12 at 8:17 a.m. and 11:20 a.m., the resident was observed with a Foley catheter in place. The record for the resident was reviewed on 10/18/12 at 1:38 p.m.	F0315	1.Resident #53 and # 165 have had the indwelling catheters discontinued. 2.Any resident with an indwelling catheter has the potential to be affected. All residents with an indwelling catheter have been reviewed for a valid medical justification. 3.Education has been completed with Licensed Nurses on Evaluation of Medical Justification for Indwelling Catheter Use. 4.The DNS/Designee will review all resident's admitted with an indwelling catheter or with an order for placement of an indwelling catheter to determine the need for the initiation and /or continued need for indwelling catheter use or if the condition can be modified, maintained, reversed, and/or eliminated, once weekly for 6 months and all findings reported to the PI committee in the PI meeting monthly or until 100% compliance	11/22/2012

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	155218	A. BUILDING 00 B. WING	10/23/2012

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	The 8/3/12 Admission assessment, indicated the resident was admitted with a Stage 2 pressure area to her left buttock which measured 7.5 centimeters (cm) x 4.0 cm. The "medical justification for an indwelling catheter" form, dated 8/3/12, indicated the Foley catheter was being "used due to contamination of Stage 3/4 pressure ulcers with urine which has impeded healing, despite appropriate personal care for the incontinence. Underlying factors supporting the initiation/continuation of the catheter, wound on coccyx. The catheter will be removed once the wound is healed. Family aware of the need for the indwelling Foley catheter secondary to wound healing. Goal to avoid contamination to the wound and surrounding area." The resident was readmitted to the facility on 8/23/12 following a hospitalization. The readmission assessment indicated the resident had no pressure sores, however; the resident had an order for the Foley catheter. An entry in the Nursing progress notes, dated 10/17/12 at 10:36 a.m., indicated the Nurse Practitioner was reviewing a need for the diagnosis for		is met as determined by the PI committee.	

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	the Foley catheter. A recommendation was made to discontinue the Foley catheter. A Physician's order, dated 10/17/12, indicated to discontinue the Foley, monitor voiding pattern and intake and output for 72 hours. Interview with the District Director of Clinical Operations on 10/23/12 at 11:20 a.m., indicated the resident's catheter had been removed and there was no justification why the catheter had been in use since readmission on 8/23/12. 2. On 10/17/12 at 8:24 a.m., Resident #165 was observed in bed. The resident was noted with an indwelling Foley catheter. The record for Resident #165 was reviewed on 10/18/12 at 10:02 a.m. The resident was admitted to the facility on 3/15/12. The resident's diagnoses included, but were not limited to, endocarditis, muscle weakness, spinal stenosis, chronic kidney disease, high blood pressure, hyposmolity, hyponatremia, urinary tract infection, and anemia.			

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	Review of Physician Orders, dated 6/13/12, indicated Foley catheter 18 French/ 10 cubic centimeters (cc). Review of Physician Progress notes, dated 6/13/12, indicated Urinary Tract Infection, Vancomycin Resistant Enterococci (VRE) Pseudomonas completed with antibiotic treatment. Review of a urinalysis culture completed on 10/11/12, indicated the resident had greater than 100,000 pseudomonas aeruginosa in which she was treated with an antibiotic. The resident did not have a VRE infection in her urine. Review of the "Medical justification for the catheter use" form, dated 6/13/12, indicated the form was incomplete related to the medical justification for the catheter. Further review indicated under the section "What are the plans to discontinue the indwelling catheter? indicated treat VRE with antibiotic (ABT)." Interview with the West Unit Manager on 10/18/12 at 1:40 p.m., indicated the diagnoses for the Foley catheter was the VRE infection in her urine. The Unit Manager thought having an infection of VRE was an acceptable indication for the Foley catheter.			

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	Interview with the Regional Interim Director of Nursing #1 on 10/18/12 at 3:50 p.m., indicated there was no medical justification for the indwelling Foley catheter. She further indicated she had called the physician and received an order today to remove the catheter due to the resident did not have VRE in her urine. 3.1-41(a)(1)			

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F0323 SS=G	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. Based on observation, record review and interview, the facility failed to ensure fall prevention devices were in place for 1 of 3 residents reviewed for accidents of the 11 residents who met the criteria for accidents. This deficient practice resulted in an injury requiring the resident to receive sutures. (Resident #62) The facility also failed to initiate a fall intervention timely for 1 of 3 residents reviewed for accidents of the 11 residents who met the criteria for accidents. (Resident #155) Findings include: 1. Resident #62 was observed on 10/17/12 at 8:34 a.m. She was seated in a Broda chair. The resident had a self releasing seat belt around her waist with the buckle in the front of her. There was no pull tab alarm attached to the resident. The resident was observed on 10/17/12 at 10:30 a.m., she was seated in a Broda chair in the West	F0323	1. Resident # 62 has had fall interventions updated. Resident # 155 has had all interventions initiated.2. All residents with fall interventions or recommendations for fall interventions have the potential to be affected. An audit of all residents with a fall has been completed for the past 30 days for implementation of recommended interventions and with the C.N.A. sheet for interventions communicated on the C.N.A. sheet.3. Education on Accidents and Supervision has been completed with all department heads and nursing staff.4. The IDT will complete safety rounds twice daily with the C.N.A sheets to validate fall interventions are implemented. These rounds will be completed for 3 months twice daily and the C.N.A sheets signed and dated when rounds competed then discussed in theIDT AM meeting to report findings X 3 months, then rounds will be completed daily X 3 months. All findings will be reported in the monthly PI meeting and the PI commitee will determine if 100% compliance has been achieved or if furhter	11/22/2012

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	Unit dining room. She had a self release belt on, there was no pull tab alarm attached to the resident. On 10/17/12 at 12:40 p.m., the resident was in the Broda chair in the dining room. There was no pull tab alarm attached to the resident. There was a self release seat belt in place. The resident was observed on 10/17/12 at 3:20 p.m., she was seated in the Broda chair in front of the Nurses' Station. There was a self release seat belt in place, there was no pull tab alarm attached to the resident. On 10/18/12 at 8:15 a.m., the resident was up in the Broda chair with a self release seat belt in place, there was no pull tab alarm in place. On 10/18/12 at 1:55 p.m., the resident was observed being transferred from the Broda chair to the bed by CNA #1 and CNA #2. The self release seat belt was on the resident. There was no Dycem (a material used to prevent sliding) in the chair under the resident and there was no pull tab on the chair attached to the resident. Interview with CNA #1 on 10/18/12 at		monitoring is required.	

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	1:55 p.m., indicated there was no Dycem and no pull tab alarm on the resident. Continued interview with CNA #1, indicated she had not applied the pull tab alarm since the seat belt was applied. CNA #1 had the West Unit CNA Assignment Sheet in her pocket. On 10/18/12 at 1:55 p.m., the CNA assignment sheet was reviewed. It indicated the resident was to have a low bed with a mat at bedside, a self release belt, a pressure alarm to the bed, a pull tab to chair, a cushion with Dycem, and a foot buddy to the Broda chair. The record for Resident #62 was reviewed on 10/18/12 at 2:08 p.m. The resident had diagnoses that included, but were not limited to, dementia, macular degeneration and seizures. The Significant Change Minimum Data Set (MDS) assessment with an assessment reference date of 9/26/12, indicated the resident had long and short term memory problems and required extensive assistance of 2 staff members with transfers. It also indicated the resident's balance was not steady when moving from a seated to a			

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	standing position and during transfers. A fall risk assessment was completed on 9/11/12 and 9/21/12. Both assessments indicated the resident had a score of 75, which indicated a high risk for falls. Review of the resident's record, indicated the resident had falls on 6/19/12, 7/6/12, 7/15/12, 7/20/12, 7/25/12, 8/4/12, 9/6/12 and 10/5/12. Review of the form titled "Post Fall Evaluation Part 2 IDT (Interdisciplinary Team) Review" that was dated 9/18/12, indicated the resident had a fall on 9/6/12. The "Interventions After Fall" section of the form indicated the intervention implemented after the fall was a seat belt. There was a Physician's Order, dated 9/11/12, that indicated the resident was to use a self-releasing seat belt. There was a Falls Care Plan with a revision date of 9/20/12, that indicated the resident was at risk for falls due to unsteady gait, psychoactive drug use, poor communication/comprehension, disease process condition, and			

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	dementia. The interventions to be used to prevent falls were: -Broda chair for proper positioning -concave mattress to bed -Dycem to Broda chair -low bed with mat next to bed -pressure alarm to bed -pull tab alarm to wheelchair -self release wheelchair belt to Broda chair The October 2012 Physician Order Sheet indicated the resident was to have a pull tab alarm to the wheelchair and a wheelchair cushion with Dycem. The resident had a fall on 10/5/12 at 11:00 a.m. Review of the form titled, "Post Fall Evaluation Part 1," dated 10/5/12, indicated the resident had a witnessed fall with injury. She was transferred to the hospital. The resident kneeled forward from her Broda chair and hit her face on a table in the dining room. The staff member assisted the resident to the floor. There was no evidence that the fall interventions were in place prior to the fall. The form titled "Post Fall Evaluation Part 2 IDT Review" dated 10/8/12 was reviewed. It indicated the			

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	resident received sutures above her right eye brow while in the Emergency Room. The interventions at the time of the fall included, Broda chair, under direct supervision of staff, in the west assisted dining room during an activity, attending a group activity listening to music, "nurse was on seen [sic] immediately and first aide was initiated resident was sent to ER for evaluation, updated doctor on blood pressures and meds (medications) for review due to low blood pressure, will re-educate CNA's on restraint use." There was a progress note dated 10/5/12 at 4:00 p.m. "Res.(resident) returned from ER. Noted with 3 sutures to rt.(right) eyebrow. No active bleeding noted, No signs of pain/discomfort. POA (Power of Attorney) notified of res . return and is on her way to facility. Report called from hospital stating all CT scans were negative..." Review of the Emergency Department notes, dated 10/5/12, indicated, "Pt. (patient) arrives BLS (Basic Life Support) via (Name if Ambulance company) to Room 3B c/o (complaint) facial lacerations r/t (related to) witnessed fall at nursing home. Pt. is awake and alert only to self per			

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	baseline, stated EMS (Emergency Medical Staff). Pt. is longboarded with cervical stabilization with rolled towels. Writer notes small laceration to Right orbit, bleeding controlled with gauze at this time. Dentition cracks noted, but unsure if this is new to today's injury. Pt. non-verbal with staff. EMS states that this is her norm. 1 cm (centimeter) laceration beneath right eyebrow, to right of eyebrow, skin tear note, V shaped, 1 cm by 1 skin closure: 5-0 nylon, Number of sutures 3. technique: simple dressing 4 x 4 sterile gauze." Interview with the West Unit Manager on 10/18/12 at 2:15 p.m., indicated the resident did not have a self release belt on, as ordered by the Physician, at the time of the fall on 10/5/12. She indicated the resident was gotten up by a Hospice CNA who did not place the seat belt on the resident. She also indicated facility staff did not apply the seat belt after Hospice staff left. The form titled (Name of Hospice Company) Hospice "Incident Report Tracking Form," dated 10/5/12, was reviewed. It indicated, "Staff at (Facility's Name) Nursing facility stated that patient fell from Broda chair striking her head, resulting in			

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	need for emergency hospital visit. Our HHA (Home Health Aide) had gotten patient up at 7:15 a.m., did care, and when she left facility patient was fully reclined in Broda and next to the Nurses' station. The fall occurred at approximately 11:00 a.m. The seat belt was not fastened/secured and was underneath patient." Interview with the West Unit Manager on 10/18/12 at 2:30 p.m., indicated the resident had Physician's Orders for a pull tab alarm and for Dycem in the chair. She indicated the fall devices were not in place as ordered during observations on 10/17/12 and 10/18/12. She indicated the devices should have been in place. 2. On 10/17/12 at 8:22 a.m., Resident #155 was observed sitting in a wheelchair eating breakfast in the dining room on the West Unit. The resident was observed with a clip chair alarm attached to her and the wheelchair. The record for Resident #155 was reviewed on 10/17/12 at 8:47 a.m. The resident was admitted to the facility on 8/27/12 from the hospital. The resident's diagnoses included,			

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	but were not limited to, acute pain due to trauma, muscle weakness, urinary tract infection, chronic ischemic disease, dysphagia, cerebrovascular disease, high blood pressure, history of falls, depressive disorder, and insomnia. Review of Physician Orders, dated 9/4/12, indicated to place the bed against the wall. A Physician Order, dated 9/10/12, indicated pull tab alarm to wheelchair, place bed against the wall and pull tab alarm to be used in bed also. Review of the Patient Evaluation, dated 8/27/12, indicated the resident was a medium risk for falls. Review of the Minimum Data Set (MDS) admission assessment, dated 9/3/12, indicated the resident was alert and oriented times three, she needed extensive assist with one person physical assist for bed mobility, transfers, dressing, and personal hygiene. The resident had no limitations to her upper or lower extremities, and the resident had a history of falls in the last month, falls in the last 2 to 6 months, has had no fractures, and has had 2 or more falls with no injury since admission.			

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	Review of the post fall evaluation #1, dated 9/28/12, indicated the resident was found on the floor at 12:45 a.m. Review of post fall #2 evaluation, dated 10/1/12, indicated the IDT team met and reviewed the fall. The decision was made to consult the Physician about Ativan (an anti-anxiety medication) being given at night. Review of Physician Orders, dated 10/1-10/14/12, indicated there was no order for the Ativan to be given routinely at night to the resident. Review of the post fall #1, dated 10/14/12 at 2:00 a.m., indicated the resident was found on the floor matt next to her bed. The resident sustained a skin tear to her left elbow. Review of the post fall #2, dated 10/17/12, indicated IDT summary review which indicated the resident had insomnia and was not sleeping at night. Review of the current plan of care that was updated on 9/4/12, indicated the resident had an actual fall with minor injury related to unsteady gait. The Nursing approaches were to continue interventions on the at risk			

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	plan, pull tab alarm to wheelchair and bed. Review of Physician Orders, dated 10/23/12, indicated Ambien (a medication used for sleep) was ordered for the resident for insomnia. Interview with the Regional Interim Director of Nursing #1 on 10/23/12 at 11:17 a.m., indicated the resident's Physician was not notified of the resident's restlessness and insomnia at night time until 10/23/12. She indicated the IDT interventions should have been completed in a more timely manner. She further indicated the Ambien was just ordered on 10/23/12 after the resident had another fall on 10/14/12. 3.1-45(a)(2)			

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F0325 SS=D	483.25(i) MAINTAIN NUTRITION STATUS UNLESS UNAVOIDABLE Based on a resident's comprehensive assessment, the facility must ensure that a resident - (1) Maintains acceptable parameters of nutritional status, such as body weight and protein levels, unless the resident's clinical condition demonstrates that this is not possible; and (2) Receives a therapeutic diet when there is a nutritional problem. Based on observation, record review and interview, the facility failed to ensure acceptable parameters of nutrition were maintained related to nutritional interventions not implemented as ordered for 1 of 1 residents reviewed for dialysis services as well as making a dietary referral after a significant weight loss for 2 of 3 residents reviewed for nutrition of the 6 who met the criteria for nutrition. (Residents #34, #52, and #211) Findings include: 1. The record for Resident #52 was reviewed on 10/19/12 at 8:45 a.m. The nutrition plan of care, dated 9/12/12, indicated the resident had the potential for weight fluctuations related to diuretic (water pill) use and lower ill-fitting dentures. One of the interventions indicated to monitor and	F0325	1. Residnt # 52 has been discharged home. Resident # 211 was referred referred to the Rd and recommendations implemented. Resident #34 has been reviewed and interventions current with resident's preferences and nutrition recommendations.2. All residents with a significant weight loss have the potential to be affected. All residents weighed weekly have the potential to be affected. All residents with a RD nutritional recommendation have the potential to be affected. An audit of all residents with a significant weight loss and with RD recommendations has been completed for completion of re-weights if indicated the implementation of nutritional recommendations. 3. All nursing staff and the RD have been educated on obtaining weights and re-weights, nutritional risk residents referral to RD and implementing RD nutritional interventions. 4. The	11/22/2012

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	evaluate any weight loss, determine percentage lost, and follow facility protocol for weight loss. Review of the resident's weight history indicated on 9/7/12, he weighed 138 pounds and on 9/13/12 he weighed 123.2 pounds. A 14.8 pound loss. There was no re-weight available for review. A Physician's order, dated 9/6/12, indicated the resident was receiving a regular diet. The only "Nutrition Services Note" available for review was dated 9/12/12, prior to the resident's weight loss. Review of the "Measuring and Documenting Height and Weight" policy on 10/19/12 at 1:50 p.m., which was provided by Regional Interim Director of Nursing #2 and identified as current, indicated the following: "If a resident has a 5 pound or more difference from the most recent weight, the scale shall be re-calibrated and the weight taken again to confirm accuracy. If a significant unplanned weight change is identified, complete a significant change of status if appropriate." Interview with the East Unit Manager on 10/19/12 at 2:33 p.m., indicated		DNS/Designee with the RD will review residents with significant weight loss, residents with re-weights for completion, and implementation of RD nutritional recommendations for implementation in the weekly NAR meeting as an on going practice of this facility. A weekly log of all residents reviewed will be maintained weekly. All findings will be reported in the monthly PI meeting and the PI commitee will determine if 100% compliance has been achieved or if furhter monitoring is required.	

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	residents are usually weighed weekly and if a discrepancy is noted, the Registered Dietitian (RD) is notified and it is up to her to ask for a re-weight. Interview with the RD and Dietary Technician on 10/19/12 at 2:45 p.m., indicated they were not aware of the resident's weight loss and would look into it. They further indicated a re-weight should be completed if there was a 5 pound gain or loss since the last weight. The resident was seen by the RD the evening of 10/19/12 and the progress note indicated the following: "resident weight reflects a 11.5 pound/8.3% weight loss since admission. Weight loss has seemed to be arrested. Visited resident today to discuss weight loss, he agrees that he originally lost weight in the hospital going from 140's to 130's, but he does tell writer that he cleans his plate now and wife also brings in food for him. He feels like there has been much improvement since he came to the facility. Recommend to start fortified foods with meals and weigh weekly for 4 weeks." 2. On 10/17/12 at 9:00 a.m., Resident #211 was eating breakfast			

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	in the main dining room. The resident was served one waffle, a bowl of hot cereal, and 2 sausage links. The resident did not receive double portions of protein. On 10/17/12 at 12:48 p.m., the resident was observed eating lunch in the main dining room. The resident was served one cup of ice cream, a cup of pudding, a regular portion of turkey a la king, seven green beans, and one biscuit. On 10/18/12 at 8:07 a.m., the resident was observed in the main dining room waiting on breakfast. At 8:34 a.m., she was served one serving of scrambled eggs, one piece of toast and one bowl of hot cereal. The resident did not receive double portions. The record for Resident #211 was reviewed on 10/17/12 at 8:28 a.m. The resident was admitted to the facility on 6/20/12 from the hospital. The resident's diagnoses included, but were not limited to, muscle weakness, difficulty in walking, atrial fibrillation, high blood pressure and osteoporosis. Review of Physician Orders on the current 10/12 recap, indicated the			

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	resident was to receive double portions of protein at every meal. Review of the resident's weights were as follows: 6/20 151 6/24 142 6/25 144 7/8 138 7/10 139 7/22 134 7/23 137 7/30 132 8/1 133 8/8 133 9/5 136 10/2 139 10/4 138 Review of the Registered Dietitian (RD) progress notes, dated 6/28/12, indicated the resident weighed 142 pounds with a reweigh of 144, which triggered a 5% weight loss over 30 days. The resident's weight loss was unplanned and undesirable. The RD indicated the admit weight may have been incorrect and will continue weekly weights to ensure accuracy. Another RD progress note, dated 7/11/12, indicated the resident weighed 138 pounds and had been relatively stable for three weeks.			

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	Review of the dietary progress note, dated 7/26/12, indicated the recommendation by the Registered Dietitian was to serve the resident double portions of protein at all meals. Review of the current plan of care updated 9/12, indicated the resident was at nutritional risk related to mechanically altered diet and thickened liquids. The Nursing approaches were monitor daily intakes, monitor for diet texture, monitor weights, and provide diet as ordered. Interview with the Dietary Food Manager on 10/18/12 at 8:40 a.m., indicated he was not aware that the resident was to receive double portions of protein at all meals. 3. On 10/18/12 at 1:55 p.m., Resident #34 was observed seated in a geri recliner in front of the Nurses' station. She had a styrofoam container on her lap and she indicated she had tacos for lunch. She indicated at that time, that she goes to dialysis every Tuesday, Thursday, and Saturday. She further indicated they pick her up around 5:00 a.m., and she returns to the facility between 10:00 and 10:30 a.m.			

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On 10/19/12 at 8:40 a.m., the resident was in bed where she was served her breakfast meal. She received extra bacon, and pancakes. She indicated the bacon was burned and she was not going to eat it. The resident was then asked if she gets the Nepro supplement and she indicated only at dialysis and not at the facility. She indicated she did not like the supplement.

The record for Resident #34 was reviewed on 10/18/12 at 2:22 p.m. The resident was admitted to the facility on 7/30/12 from the hospital. Prior to her hospitalization she was residing in another long term care facility.

The resident's diagnoses included, but were not limited to, diabetes, anemia, high blood pressure, renal failure, and hypercholestremia.

Review of Physician orders, dated 9/12/12, indicated "dietitian to see for low albumin for supplement and increase protein food." The resident was sent to the hospital as a direct admit on 9/14/12 from the dialysis center.

Further review of Physician Orders,

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	dated 8/10/12, indicated to add double protein at all meals. Another Physician Order, dated 8/3/12, indicated Nepro vitamin and Nepro eight ounces twice a day. The resident returned to the facility on 10/1/12. Review of Physician Orders at that time, indicated the Nepro supplement was not reordered. It was not on the Medication Administration Record, and there was no documentation the resident was receiving the Nepro at the facility. There was no documentation the RD had assessed the resident for the low albumin level in the month of September and October 2012. The RD was at the facility on 9/17, 9/24, 10/1, 10/6, 10/7, and 10/12/12. The Dietary Tech was at the facility on 9/14, 9/21, 9/25, 9/26, 10/3, 10/5, 10/10, and 10/12/12. Review of the RD progress note, dated 10/7/12, indicated the resident had a weight gain of seven pounds. The resident had adequate intakes and was receiving a multivitamin and vitamin C. The RD addressed the resident's recent lab work from the hospital and made no other recommendations.			

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	Review of a Fax from the Dialysis Center RD, dated 10/9/12, indicated the resident's albumin level was low and she wanted the resident to continue the protein supplement and be provided high protein foods. Interview with the RD on 10/19/12 at 11:13 a.m., indicated she had seen the resident and assessed her on 10/7 and did not make any recommendation for her to continue the Nepro supplement. She further indicated that she had not spoken to or interviewed the resident because on that day she was at the dialysis center. The RD was unaware the resident did not always eat the facility's food, and she was unaware the resident did not like the Nepro supplement. The RD further indicated that she had not spoken to the dialysis RD since starting at the facility in 9/12. She further indicated she was unaware of the Fax report from the Dialysis Center RD dated 10/9/12. 3.1-46(a)(1)			

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F0363 SS=C	483.35(c) MENUS MEET RES NEEDS/PREP IN ADVANCE/FOLLOWED Menus must meet the nutritional needs of residents in accordance with the recommended dietary allowances of the Food and Nutrition Board of the National Research Council, National Academy of Sciences; be prepared in advance; and be followed. Based on observation, record review and interviews, the facility failed to follow the menu as prepared in advance by the Registered Dietitian. This had the potential to effect 130 residents of the 136 residents who resided in the facility. Findings include: On 10/15/12 at 12:15 p.m., the West Unit dining room was served lunch. The residents who received regular diets were given baked beans. No resident received sauerkraut. The menu posted outside the dining room indicated the residents were to receive sauerkraut. On 10/17/12 in the Main dining room, during the lunch meal, the residents who were on a regular diet, were served green beans. No residents received peas.	F0363	1. 130 Residents had the potential to be affected. The dietary manger was provided written counseling. A new dietary manger will start on 11/26/2012. 2. Of the 130 residents with the potential to be affected no adverse affect was noted. The Dietary staff and dietary manager have been in-serviced on following menus, reviewing spreadsheets before the mealaff on the tray line and having spreadsheets available to st and posting substitutions.3. In-serving with all dietary employees on Menus, spreadsheets, portion sizes, Production pull carts will be done the day before , and Substitutions has been completed. 4. The DM/Dietary consultant will audit the trays for accuracy with following menus and posting substitutions twice daily X 5 days a week X 3 months then weekly X 3 months. All findings will be reported in the monthly PI meeting and the PI commitee will determine if 100% compliance has been achieved or if furhter monitoring is required.	11/22/2012

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	The menu posted outside of the dining room indicated the vegetable to be served was peas. On 10/17/12 during the noon meal, the residents on the East unit received two Swedish meatballs. Continued observation on 10/17/12 at 12:37 p.m., indicated the residents in the Main dining room were served their food. The residents in the Main dining room were served three Swedish meatballs. Review of the current menu and spreadsheets for Monday, week two, indicated the residents were to receive sauerkraut. Review of the menu and spreadsheets for Wednesday, week two, indicated the residents were to receive peas and not green beans. Review of the spreadsheet for a regular diet for Thursday, week two, indicated the residents were to receive 3 meatballs. Interview with the Dietary Food Manager on 10/17/12 at 1:03 p.m., indicated the menu was not changed at each dining room to reflect what he had substituted. He further indicated he did not have enough sauerkraut			

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	for everyone on Monday and he did not have peas to serve on Wednesday. Interview with Dietary Cook #1 on 10/18/12 at 1:03 p.m., indicated he had thought the resident's were to receive two meatballs per serving. 3.1-20(i)(4)			

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F0368 SS=C	483.35(f) FREQUENCY OF MEALS/SNACKS AT BEDTIME Each resident receives and the facility provides at least three meals daily, at regular times comparable to normal mealtimes in the community. There must be no more than 14 hours between a substantial evening meal and breakfast the following day, except as provided below. The facility must offer snacks at bedtime daily. When a nourishing snack is provided at bedtime, up to 16 hours may elapse between a substantial evening meal and breakfast the following day if a resident group agrees to this meal span, and a nourishing snack is served. Based on observation, record review, and interview, the facility failed to ensure the meals were served on time to the residents in the Main Dining Room, the South, and West Dining Rooms. This had the potential to effect 130 residents of the 136 residents who resided in the facility. Findings include: On 10/15/12 at 12:06 p.m., the lunch trays arrived to the West Unit Dining Room. The second cart of lunch trays arrived to the unit at 12:14 p.m. and were placed in the Dining Room. At 12:15 p.m., the staff were	F0368	1. 130 residents had the potential to be affected. No adverse affect was noted. All meal times have been posted within the 14 hour timeframe.2. 130 Residents had the potential to be affected. No adverse affects was noted from meals served not served timely. Meal times have been posted in all dining rooms. Department managers have a dining room assignment to monitor timeliness in serving meals daily. The Dietary manager was counseled and a new Dietary Manager will start on 11/26/2012.3. In-servicing has been completed with nursing staff, department heads and dietary staff on ensuring meals are served on	11/22/2012

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	observed to pass the first tray from the first cart. On 10/15/12 at 12:25 p.m., the first cart of lunch trays arrived to the South Unit. The second cart arrived to the unit at 12:30 p.m. At that time, the trays were passed to the residents. On 10/15/12 at 12:38 p.m., the Main Dining Room was served lunch. On 10/16/12 at 8:50 a.m., the Main Dining Room was served breakfast. On 10/17/12 at 8:40 a.m., the Main Dining Room was served breakfast. On 10/18/12 at 8:15 a.m., the West Unit Dining room just started to pass their breakfast trays. At that time, the main dining room announced they were ready to serve breakfast. CNA #6 indicated at that time, that she still had residents to get up and was not ready to go down to the dining room to pass trays. Interview with the Consultant Dietitian on 10/18/12 at 8:27 a.m., indicated the kitchen staff were ready to serve the meals; however, they needed to wait on the West Unit CNA's to come		time.4. The DM/Dietary consultant will audit meal service daily x 5 days a week for 1 month, then twice weekly x 1 month then weekly for 4 months. A log will be maintained by department managers of meal start time daily X 3 months. All findings will be reported in the monthly PI meeting and the PI commitee will determine if 100% compliance has been achieved or if furhter monitoring is required.	

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	and pass trays in the Main Dining Room. Review of the meal times posted outside of the Main Dining Room indicated breakfast was to be served at 8:15 a.m., and lunch at 12:30 p.m. The South Unit dining room was to be served breakfast at 8:00 a.m. and lunch was scheduled for 12:20 p.m. The West Unit dining room was to be served breakfast at 7:35 a.m. and lunch was scheduled for 12:00 p.m. Interview with the Dietary Food Manager on 10/18/12 at 8:40 a.m., indicated the breakfast time posted in the Main Dining Room was 8:15 a.m. 3.1-21(c)			

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F0371 SS=F	483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions Based on observation and interview, the facility failed to store or serve food under sanitary conditions related to glove usage, hair restraints, dirty oven racks and uncovered and not labeled food for 1 of 1 kitchens. This had the potential to effect 130 residents of the 136 residents who resided in the facility. (The Main Kitchen) Findings include: 1. During the Brief Kitchen Sanitation Tour on 10/15/12 at 9:34 a.m., the following was observed: A. There were 12 individual servings of cottage cheese in plastic dishes located in the reach-in cooler that had no date. There were two individual servings of yogurt in plastic containers that had no date on them. There were 18 individual servings of applesauce containers that were uncovered and had no date on them.	F0371	1. 130 residents had no adverse affects. The dietary manger destroyed the items in the reach in that had no date on them. The Dietary Cook #1 has been in-serviced on sanitary conditions related to glove use and using utensils, the two convection ovens were cleaned and the maintenance supervisor completed PI for hair restraints.2. 130 residents had the potential to be affected. All items in the reach in have been covered and dated, the dietary cook has PI regarding sanitary conditions, the maintenance supervisor has had PI for Hair restraints, the ovens have been cleaned and will be on a daily (light) and weekly (through) cleaning schedule. The new dietary manager starts 11/26/2012.3. In-servicing with dietary staff on Food and Supply Storage with emphasis on labeling food with a "use by date" and covering items in the reach in, Principles of Safe Food Handling with emphasis on sanitary conditions related to glove use and using utensils, Kitchen cleaning schedule and use of hair restraints in the	11/22/2012

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	None of the above items were dated or had lids to indicate a "use by" date. There were three packages of yogurt floating in water with some ice cubes in a metal container. Interview with the Dietary Food Manager at the time, indicated the above food items should have been covered and labeled with a date. 2. During the Full Kitchen Sanitation Tour on 10/22/12 at 11:06 a.m., the following was observed: A. Dietary Cook #1 was observed preparing the noon meal. At that time, he was observed taking food temperatures. After taking the food temperatures, the cook removed his gloves and threw them away. He then placed new gloves on both of his hands and did not wash his hands with soap and water or use an alcohol gel. He then started to prepare the residents' meal trays. The cook was observed preparing the meal trays by picking up a couple of pieces of raw fresh spinach with his gloved hands and placing it on the plates. He did not use utensils to do this. He then placed one piece of eggplant parmesan on the plates by using a spatula and then removing		kitchen.4. The Dietary Manager / Dietary consultant will complete a Nutrition Services "Quick Rounds" audit daily x 5 days a week for 3 months and then weekly for 3 months. The ED will complete a Nutrition Services "Quick Round" audit weekly for 3 months. All findings will be addressed and corrected immediately and then, All findings will be reported in the monthly PI meeting and the PI commitee will determine if 100% compliance has been achieved or if furhter monitoring is required.	

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	the entire piece by touching it with his gloved hands and placing it on the plate. He was also observed touching the plates, other utensils, the front of his apron and picking up a towel to wipe off the counter tops with his gloved hands that he had touched the eggplant and the raw fresh spinach with. The cook served 12 plates before the Dietary Food Manager was informed. Interview with the Dietary Food Manager at the time, indicated the cook should be using utensils to pick up the food and to scrape it onto the resident's plates and not his gloved hands. B. The two convection ovens were observed with a heavy accumulation of grease and burned food on the inside, as well as on the oven racks and on the bottom of both ovens. C. During the tray line, the Maintenance Supervisor was observed to enter the kitchen and walk completely around the steam table without a hair restraint on his head. 3.1-21(i)(3)			

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F0412 SS=D	483.55(b) ROUTINE/EMERGENCY DENTAL SERVICES IN NFS The nursing facility must provide or obtain from an outside resource, in accordance with §483.75(h) of this part, routine (to the extent covered under the State plan); and emergency dental services to meet the needs of each resident; must, if necessary, assist the resident in making appointments; and by arranging for transportation to and from the dentist's office; and must promptly refer residents with lost or damaged dentures to a dentist. Based on observation, record review and interview, the facility failed to ensure dental evaluations were provided for 2 of 2 residents reviewed for dental services with broken and/or missing teeth of the 2 residents who met the criteria for dental services. (Residents #57 and #62) Findings include: 1. Resident #57 was observed on 10/17/12 at 8:14 a.m., in the South Unit dining room. The resident had missing teeth on his upper mouth. Interview with the resident's wife on 10/15/12 at 1:48 p.m., indicated the resident's partial plate on the top was missing. The record for Resident #57 was reviewed on 10/17/12 at 8:47 a.m.	F0412	1. Resident has been seen by a dentist for his missing partial denture. Resident #62 has a dental services apointment scheduled.2. All residents needing a dental evaluation have the potential to be affected. An audit of all residents for dental services has been completed and any resident needing dental services scheduled an evaluation with the consent of the resident and responsible party.3. All nursing staff and department managers have been educated on dental services.4. The DNS/Designee will audit all admissions and readmissions for indication on the initial nursing assessmnet for dental services as an on going practice of this facility. The DNS and SSD will monitor reports or greivances for reports of missing dental appartus and follow thru with dental services if indicated as an ongoing practice of this facility. The SSD will keep maintain a log	11/22/2012

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	The resident had diagnoses that included, but were not limited to, diabetes, dementia and Parkinson's disease. There was no dental evaluation noted in the resident's record. There was a form signed by the resident's wife and dated 1/16/12, that indicated the resident could be seen by the facility dentist. There was a physician order, dated 6/11/12, that indicated, "Change diet to puree d/t (due to) dental status." The order was written by the Speech Therapist. A form titled "Therapy Screen" that was dated 6/11/12, and signed by the Speech Therapist was reviewed. It indicated, "Per nsg (nursing) pt's (patient's) dentures missing at this time. Given decreased cognitive status and overall generalized weakness, puree diet is reasonable at this time until dentures are found or pt. refitted." Under the Comment section, "Pt's wife is in agreement with decision to change diet to puree at this time. Skilled ST (speech therapy) not required to treat pt at this time."		of residents needing dental services, when evaluation of service is to be completed and results of evaluation. All logs and findings will be reported in the monthly PI meeting and the PI commitee will determine if 100% compliance has been achieved or if furhter monitoring is required.	

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	Interview with the South Unit Manager on 10/17/12 at 10:45 a.m., indicated she was aware the resident had a missing partial denture. She indicated the Speech Therapist was asked to evaluate the resident and make a recommendation for the appropriate diet. She indicated the Speech Therapist indicated the resident would benefit from a pureed diet. The South Unit Manager indicated the Social Service staff was responsible for setting up dental services for the residents. Interview with Social Service Staff #1 on 10/17/12 at 10:37 a.m., indicated she was not aware that the resident's partial denture was missing. She indicated she was responsible for setting up referrals to the Dentist. She indicated the wife signed a consent for the resident to be seen by the dentist on 1/16/12. She also indicated there was no dental assessment completed by a dentist in the resident's record. She indicated the resident should have been evaluated by the Dentist when the partial denture was missing. 2. Resident #62 was observed on 10/17/12 at 8:34 a.m. The resident was in a Broda chair and her mouth was open. There was a broken tooth			

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	on the lower portion of her mouth, the teeth in her mouth were discolored and were in poor condition. The record for Resident #62 was reviewed on 10/18/12 at 2:08 p.m. The resident had diagnoses that included, but were not limited to, dementia, hypertension and depression. There was a Nutritional Assessment, dated 9/12/12, that indicated the resident received pureed food and nectar thickened liquids. It also indicated in the "Oral Health" section that the resident had "caries and decay." The form titled "Patient Nursing Evaluation Part 3," dated 9/11/12, was reviewed. It indicated the resident had "missing teeth" and "caries/decay." There was no dental evaluation in the resident's record. There was a Care Plan initiated on 10/1/12 that indicated, "res (resident) is currently on hospice services. Res will receive medically related services. Dental services, podiatry services, vision services, and audiology services. One of the interventions			

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	was, "evaluate need and report to physician, obtain physician's order for services, arrange appointment, have necessary documentation ready to give to doctor on next visit." Interview with Social Service Staff #1 on 10/18/12 at 2:15 p.m., indicated the resident had not been seen by a dentist since admission on 12/27/11. She indicated there was no documentation that indicated the family did not want the resident to be seen by the facility dentist. She indicated there should be a consent indicating what the family desires related to dental services. 3.1-24(a)1 3.1-24(a)(3)			

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F0428 SS=E	483.60(c) DRUG REGIMEN REVIEW, REPORT IRREGULAR, ACT ON The drug regimen of each resident must be reviewed at least once a month by a licensed pharmacist. The pharmacist must report any irregularities to the attending physician, and the director of nursing, and these reports must be acted upon.			
	Based on record review and interview the facility failed to ensure the pharmacist's recommendations were acted upon in a timely manner for 4 of 10 residents reviewed for unnecessary medications. (Resident's #62, #83, #168 and #165) Findings include: 1. The record for Resident #165 was reviewed on 10/18/12 at 10:02 a.m. The resident was admitted to the facility on 3/15/12. The resident's diagnoses included, but were not limited to, endocarditis, muscle weakness, spinal stenosis, chronic kidney disease, chronic airway obstruction, congestive heart failure, generalized osteoporosis, high blood pressure, acute edema of the lung, vitamin D deficiency, hyponatremia, urinary tract infection, anxiety state, depressive disorder, hyperlipidemia, and anemia.	F0428	1. Resident #62, 83, 168, and 165 have had pharmacy recommendations acted upon.2. All resident's with a pharmacy recommendation have the potential to be affected. All pharmacy recommendations for the past 6 months have been reviewed and acted upon if necessary. 3. All nursing staff have been educated on Pharmacy Recommendations and the process for implementation.4. The DNS/Designee will review the monthly pharmacy recommendations within one week after sending to the MD/NP for timely follow up and implementations. This will be an on going practice monthly of the facility. All findings will be reported in the monthly PI meeting and the PI commitee will determine if 100% compliance has been achieved or if furhter monitoring is required.	11/22/2012

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	Review of Physician Orders on the current 10/12 recap, indicated the resident receives Protonix (a medication used to treat gastroesophageal reflux) and Astelin (an anti-histamine) Nasal Spray. Review of the Pharmacist recommendation, dated 4/20/12, indicated "Please provide diagnoses to support the routine use of Protonix and Astelin Nasal Spray." Interview with the District Director of Clinical Operations on 10/19/12 at 10:00 a.m., indicated they had just called the Physician to obtain the diagnoses for the Protonix and the Nasal Spray. She further indicated there were no diagnoses in the clinical record for the use of those two medications. 2. The record for Resident #168 was reviewed on 10/19/12 at 12:19 p.m. The resident had diagnoses that included, but were not limited to, stoke with hemiplegia, depression and aphasia (difficulty with speech). There was a form titled "Note to Attending Physician/Prescriber" that indicated, "Resident receives Celexa (an anti-depressant) 20 milligrams (mg) qd (every day). Regulations require an annual dose reduction			

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	attempt unless clinically contraindicated. Please consider a dosage reduction at this time or document why this may not be appropriate." The form was dated 5/22/12 and was signed by the Pharmacist. Review of the record indicated there was no evidence that the Physician was notified of the Pharmacist's recommendation and there was no evidence that the physician responded to the recommendation. 3. The record for Resident #62 was reviewed on 10/18/12 at 2:08 p.m. The resident had diagnoses that included, but were not limited to, dementia, macular degeneration and seizures. There was a form titled "Note to Attending Physician/Prescribe" that indicated, "Could you please provide a diagnosis for the following routine medications? 1) Ropinirole (a medication used for restless leg syndrome 2) prilosec (a medication used to treat acid reflux)?" The form was dated 4/19/12 and signed by the Pharmacist. There was another form titled "Note to Attending Physician/Prescribe" that			

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	indicated, "Resident receives Lexapro (an antidepressant medication) 10 mg every hs (every evening). Regulations require a dosage reduction attempt twice within the first year unless it is clinically contraindicated. Please consider a dosage reduction at this time or document why this may not be appropriate. The form was dated 6/25/12 and was signed by the Pharmacist. A form titled "Note to Attending Physician/Prescribe" that indicated, "Resident receives Enablex (a medication used to treat an overactive bladder) and Ropinirole. Could you please provide a diagnosis to support their use." The form was dated 7/23/12 and signed by the Pharmacist. Review of the record indicated there was no evidence the Physician was notified of the Pharmacist's recommendations. There was no evidence the Physician responded to the recommendations. 4. The record for Resident #83 was reviewed on 10/17/12 at 1:13 p.m. The resident had diagnoses that included, but were not limited to, Huntington's chorea, dysphagia (difficulty swallowing) and			

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	hypertension. There was a form titled "Note to Attending Physician/Prescribe" that indicated, "Could you please provide a diagnosis to support the routine use of Claritin (an allergy medication)?" The form was dated 4/20/12 and signed by the Pharmacist. Review of the record, indicated there was no evidence that the Physician was notified of the Pharmacist recommendations and there was no evidence that the Physician responded to the recommendation. The policy titled, "Pharmacist Consultation" provided by Minimum Data Set (MDS) Coordinator #2, on 10/19/12 was reviewed. She indicated the policy was current. The policy indicated "The pharmacist conducts monthly medication regimen reviews (MRR). The results of the review were documented by the pharmacist. The MRR is a part of each patient's clinical record. If documentation of the findings was not in the active record, it was maintained within the center and readily available for review. The Director of Nursing and the			

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	attending physician act on the pharmacist's review by: A.) For those issues that required physician intervention, the physician either accepts and acts upon the report and potential recommendation, or B.) Rejects all or some of the report and provides a brief explanation of why the recommendation is rejected such as a dated progress note." Interview with the Director of Nursing on 10/18/12, indicated the expectation was for the facility and the Physician to respond to the Pharmacist's review within 7 days. She indicated there was no evidence in the resident's records that the Physicians were notified of the Pharmacist's recommendations. She also indicated there was no evidence that the Physicians acted upon the recommendations. 3.1-25(j)			

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F0441 SS=D	483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection. (a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections. (b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease. (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice. (c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection. Based on observation, record review, and interview, the facility failed to	F0441	1. Resident # 184 has had no adverse effect. LPN #5 has been	11/22/2012

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	155218	A. BUILDING 00 B. WING	10/23/2012

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	ensure each licensed staff member washed their hands after touching a resident during medication pass for 1 of 4 licensed staff members observed during medication pass. (Resident #184) Findings include: On 10/19/12 at 5:18 a.m., LPN #5 was observed preparing Resident #184's medication. The LPN crushed the resident's medication and placed them in pudding. She then opened a Lidoderm patch (a patch to control pain). The LPN first took the resident's blood pressure with her bare hands, and then gave him his medication. The LPN then removed the resident's old Lidoderm patch on his back with her bare hands and placed the new patch on the resident's back with her bare hands. She then left the room and pushed her cart to the Nurses' station. The LPN then proceeded to sign out the resident's medications in the book and touched other items on her cart. She then walked behind the Nurses' station and sat down to finish other paper work. The LPN did not use alcohol gel or wash her hands with soap and water before leaving the resident's room.		educated on Hand Hygiene/Hand washing.2. All residents receiving medications from LPN #5 had the potential to be affected. LPN #5 has been educated on Hand Hygiene/Hand washing.3. Education has been completed with all employees on Hand Hygiene with emphasis on hand washing.4. The DNS/Designee will complete infection control rounds with emphasis on hand washing weekly for 3 months, then monthly for 3 months.All findings will be addressed immediately. All findings will be reported in the monthly PI meeting and the PI commitee will determine if 100% compliance has been achieved or if further monitoring is required.	

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	Review of the current 8/11 "Hand Hygiene/Handwashing" policy provided by the South Unit Manager, indicated Hand Hygiene was to be performed after touching bare parts of the body other than clean hands and clean, exposed portions of arms. After contact with a patient's intact skin (e.g., when taking a pulse or blood pressure and lifting a patient). Interview with the LPN at the time, indicated she did not wash her hands or use an alcohol gel before leaving the resident's room. Interview with the South Unit Manager on 10/23/12 at 10:55 a.m., indicated the nurse should have washed her hands with soap and water or used alcohol gel before leaving room. 3.1-18(l)			

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F0465 SS=F	483.70(h) SAFE/FUNCTIONAL/SANITARY/COMFOR TABLE ENVIRON The facility must provide a safe, functional, sanitary, and comfortable environment for residents, staff and the public. Based on observation and interview, the facility failed to ensure the kitchen was clean related to dirty wall tile, dirty white PVC pipes, dirty ceiling vents, dirty cart wheels, and dirty garbage cans. The facility also failed to ensure the residents' environment was clean and in good repair related to stained floor tile, marred walls, marred floors, cracked floor tile, and heating units not attached to the walls for 1 of 1 kitchen areas and for 2 of 3 units. (The Main Kitchen, West Unit, and South Unit). This had the potential to effect 136 residents who resided in the facility. Findings include: 1. During the Brief Kitchen Sanitation Tour on 10/15/12 at 9:34 a.m., the following was observed: A. The garbage disposal in the dish room was rusty, dirty and had peeling paint. B. The lower white wall tile was dirty with food splattered all along the walls in the dish room. The beige plastic	F0465	1. The two heating units in the South Dining room are repaired and attached to the wall properly. All areas in room 9 and room 15 on the south unit have been cleaned and replaced or repaired. All residents residing on the south unit had no adverse affect. Staff working the South unit had no adverse affect.The cracked tiles in the West Unit Dining room have been replaced. The entertainment center has had the edging replaced. The laminate edging in the pantry has been replaced. The cove base in the men's shower room has been replced. In rooms 101, 102, 107, 112, 113, and 132 the marred walls, scuffed floors, green stains on the bathroom faucet, cracked floor tiles, stains in bathrooms, dirt and dust have been cleaned or repired. The walls with two paint colors have been painted one colorand the closet door in room 132 replaced.The dietary and maintenance staff initiated cleaning immediately in the kitchen on the following items: wall tile, PVC pipes, ceiling vents, transportation cart wheels and garbage cans and all items placed on a cleaning schedule.2. 71 residents residing on the west	11/22/2012

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	lower back splash was also dirty with food splattered all over it. C. The ceiling in the dish room was food stained throughout. D. There were two transportation carts that were dirty. E. The floor drain located under the dish machine was dirty with adhered food debris. The white PVC pipes by the drain under the dish machine were dirty and stained. F. There were two ceiling vents that were dirty with a heavy accumulation of dirt and dust. H. The tan garbage can by the hand washing sink was observed with food splattered and dirt noted on the outside. 2. During the Full Kitchen Sanitation Tour on 10/22/12 at 11:06 a.m., the following was observed: A. The pipes behind the stove were greasy and dirty. There was also a large accumulation of food debris and dirt noted on the floor behind the stove and the large skillet. B. The wall tile behind the stove and		unit had the potential to be affected. No adverse affect has been noted. All areas of concern identified have been cleaned or repaired. All staff have been in-serviced on Maintenance slips and communication. The kitchen is cleaning dirty wall tile, dirty PVC pipes, dirty ceiling vents, dirty cart wheels and dirty garbage cans.3. In-servicing has been completed with housekeeping, dietary, and maintenance on General Environmental Conditions, Patient's Environment, Kitchen and housekeeping cleaning schedule. 4. The ED/Designee will complete center rounds, review greivances related to environment and maintenance slips twice weekly x 3months, then weekly x 3 months to evaluate the effectiveness of interventions implemented and monitor housekeeping cleaning and preventative maintenance issues . The Dietary Manager / Dietary consultant will complete a Nutrition Services "Quick Rounds" audit that includes the kitchen cleaning schedule daily x 5 days a week for 3 months and then weekly for 3 months. The ED will complete a Nutrition Services "Quick Round" audit weekly for 3 months, then monthly for 3 months. All findings will be addressed and corrected immediately and then, All findings will be reported in the monthly PI meeting and the PI commitee will	

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	ovens were dirty with dried food spillage. C. The wall tile behind the three compartment sink was dirty and greasy with a heavy accumulation of dirt. D. The white PVC pipes located under the 3 compartment sink, under the food prep counter, and by the floor drain had a heavy accumulation of food spillage and was dirty. Interview with the Dietary Food Manager on 10/22/12 at 11:40 a.m., indicated all of the above areas were in need of cleaning. 2. The following was observed during the Environmental Tour on 10/19/12 at 1:35 p.m., with the Maintenance Supervisor, the Maintenance Assistant, the Housekeeping Supervisor and the Environmental Consultant. The South Unit A. Two of three heating units in the South Dining Room were not attached to the wall properly and were in need of repair. Interview with the Maintenance Supervisor at that time, indicated the staff sometimes sat on the units causing them to pull away		determine if 100% compliance has been achieved or if further monitoring is required.	

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	from the wall. B. In Room 9, the floor in the bathroom around the toilet was stained and in need of cleaning or replacement. There were 2 residents residing in the room. C. In Room 15, the bathroom sink vanity had 2 one foot sections of edging missing. There were 2 residents residing in the room. The West Unit A. The floor in the West Unit Dining Room had numerous cracked tile that were in need of replacement. The entertainment center had a 7 foot section of laminate edging that was missing. 71 residents resided on the West Unit. B. A two foot section of laminate edging was missing on the sink in the pantry. C. The cove base in the men's shower room had a 6 foot section that was marred with holes. D. In Room 101, there were black scuff marks on the floor tile at the foot of bed one. The wall behind the head of bed two was marred. The faucet in			

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	the bathroom had a green stain. There were 2 residents residing in the room. E. In Room 102, there was an accumulation of dust and debris along the edge of the cove base. There was a cob web behind the door in the room. There were 2 residents residing in the room. F. In Room 107, the wall by the closet had been painted with two different colors of paint. Two residents resided in the room. G. In Room 110, there were cracked floor tiles noted in the room. 10 tiles were cracked and in need of replacement. There were 2 residents residing in the room. H. In Room 112, the wall below the window was marred and missing paint. The floor was scuffed with black areas between bed one and bed two. There were 2 residents residing in the room. I. In Room 113, the bathroom floor had a black stain in front of the toilet. There were 2 residents residing in the room. J. In Room 132, the bathroom ceiling			

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	vent had an accumulation of dirt and dust. The closet door was missing and not in the room. There were 2 residents residing in the room. Interview with the Maintenance Supervisor and the Housekeeping Supervisor at the time of the tour, indicated all of the above was in need of repair or cleaning. 3.1-19(f)			